THE IMPACT OF BATTERING AND SHELTERING ON SELECTED PSYCHOLOGICAL STATES OF BATTERED WOMEN

By

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To my parents

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The problem of this study was to determine the emotional consequences of battering and sheltering through the use of objective clinical diagnostic instruments. The following questions were addressed: Are battered women significantly more depressed and/or anxious than non-battered women? What is the impact of treatment at the shelter on symptom reduction? What prompted battered women to leave their abusive partners at that particular point in their lives? How do they describe the subjective meaning of their experience at the shelter?

Information was obtained from 40 battered and sheltered women and 30 non-battered women who sought medical attention from a women's health clinic. During the first interview all respondents completed the Background Information Questionnaire, the Beck Depression Inventory, and the State-Trait Anxiety Inventory. Three weeks later the depression and anxiety scales were administered again to both groups. Also, in the follow-up interview the battered women completed the Evaluation Form of the Shelter Experience.

Descriptions of demographic features of the experimental and control groups as well as the nature of the battering experience are presented. Data analysis of the pretesting results revealed that battered women constitute a high-risk population for both depression and anxiety. In contrast, the scores of the non-battered women group fell within the normal range and were not indicative of clinical depression and/or anxiety. The impact of treatment received at the shelter is not clear-cut. The results suggest that the treatment does contribute significantly to changing the state anxiety of battered women in the desired direction, but does not play a significant role in drastically reducing trait anxiety and depressive symtomatology.

The three most frequently stated reasons for severing the abusive relationship were (1) the women's determination to stop tolerating abuse and harassment, (2) fear of being killed, and (3) the women's pervasive sense of hopelessness in regard to changing the abusive behavior.

Descriptive information regarding their perception and evaluation of the services provided by the shelter is presented. Also, the limitations of the study and alternative interpretations of the results are addressed.

CHAPTER I
INTRODUCTION

An extensive review of the literature reveals that wife battering is considered to be a pervasive and universal social phenomenon rather than an individual pathology of the victim or the offender. For many years, marital violence has remained mostly behind the closed doors of private homes and below the level of public consciousness.

The recognition of wife abuse as a pressing and dangerous public problem which requires carefully designed services has been noted during the last decade, probably with the advent of the women's movement. Walker (1980) stated that talking about such assaults, reporting them to police, breaking the taboo of silence and discussing the abuse in psychotherapy sessions, or even conducting research on wife abuse has not become popular until the past five years.

Statistical evidence gathered from diverse sources of information such as police reports, court rosters, emergency hospital admittance files, and academic studies confirms that wife beating is a startlingly common problem in American society; it is far more common than generally supposed. Estimates stating that 50% of all American wives are battered are not uncommon. It is believed that there were between 26 and 30 million abused spouses in the U.S. in 1976 (Langley & Levy, 1977; Martin, 1976; Straus, 1977-78; Walker, 1979).

Domestic violence can result not only in severe injury to the victim, but also death. Women who are abused generally are beaten

repeatedly and suffer injuries serious enough to require emergency medical attention. A study at one Connecticut hospital found that almost half of the 1,400 injuries brought by 481 women to the hospital's emergency room resulted from beatings by their husbands or boyfriends (Stark, Flitcraft, & Frazier, 1979).

Battering tends to escalate with time, leading, in some instances, to homicide or suicide. In 1972, Kansas City police found that 40% of all homicides were cases of spouse killing spouse. In almost 50% of these cases, police had been summoned five or more times within a 2-year period before the murder occurred (Martin, 1976). Fields (1978) indicated that in the United States, more than 1,000 women annually are victims of spousal homicide.

Domestic violence also endangers the lives of police officers who respond to domestic disturbance calls. According to the FBI, one out of every five police officers killed in the line of duty in 1974 died while trying to break up a family fight (Martin, 1976).

Consequences of abuse can also be longstanding, and the hypothesis that violence leads to violence is well documented in the literature. Gelles (1982) claims that one of the consistent conclusions of domestic violence research is that individuals who have experienced violent and abusive childhoods are more likely to grow up to become child and spouse abusers than individuals who experienced little or no violence in their childhood years. Husbands who were categorized as being reared in the most violent homes had a rate of wife abuse 600 times greater than husbands reared in the least violent homes (Gelles,

1982). Steinmetz (1977a) reports that even less severe forms of violence are passed on from generation to generation.

The association between wife abuse and child abuse is also observed empirically. While there is little information available, Fleming (1979) reported the following findings:

1. Men who abuse their wives tend toward child abuse.

2. Women who are abused may vent their rage and frustration on their children.

3. Children frequently become "accidental" victims of spouse assault.

4. Just as children who are abused tend to grow up to be child abusers, children who witness wife assault tend to grow up to be wife beaters and beaten wives.

To sum up, the severity, frequency, chronicity, dangerousness, generational cycle of violence, and the negative impact of violence on the lives of many women, men, and their children, as well as others who become involved in the marital disputes, make the issue of domestic violence a particularly important phenomenon and worthy for serious investigation.

Problem Statement

It has been indicated by several researchers (Carlson, 1977; Hartik, 1982) that very little systematic research has been conducted in this area. The limited data collected tend not to be oriented toward service delivery. It is noted that these pioneer writers in the field of wife abuse focused primarily upon the sociological or legal aspects

of the issue, and a paucity of statistical empiricism of the psychological approach is evident.

Walker (1981) confirmed the lack of information that deals with the relationship between the battering experience and the mental health status of the abused women. She stated that up to this point there are no records that indicate any consideration was given to the impact of psychological injuries that might result from such abuse.

Warner (1982) recognized the importance of the process of assessment from a holistic point of view. She believed that understanding the dynamics of the violence and assessing the emotional factors that occur after an act of violence may facilitate in determining the services and the referral sources essential for adequate survival of each victim.

It is apparent that the demands to provide mental health services to the victims and their families have increased as a result of more exposure and recognition of the problem. Therefore, clinicians should assess systematically whether battered women constitute a high risk population for depression and anxiety and, consequently, should take the proper measures required for clinical intervention.

As a result of the scarcity of available information regarding the emotional states of battered women, the present study will focus upon the following objectives:

1. Assessment of selected psychological functioning of battered and non-battered women. The frequency and severity of depression and anxiety experienced by the two groups will be evaluated through the use of objective psychological instruments.

2. This study aims also to examine the impact of treatment at the spouse-abuse shelter on changing the levels of depression and anxiety.

3. Another objective of the study is to gather information regarding the needs and the subjective meaning of the battered women's experience at the shelter.

4. Finally, the study aims to explore the precipitating events and the individualized reasons that led each woman to decide to leave the abusive situation and seek help from the shelter.

The problem covered by the study might be further clarified by asking the following questions:

1. Do the levels of depression and anxiety differ in women who have been battered from women who have not been battered?

2. Does the treatment women receive at the shelter contribute to reducing the intensity of depression and anxiety experienced by battered women?

3. What are the needs of battered women from the perception of the victims themselves?

4. What happened at this particular moment of the victim's life that triggered her initiative to leave the abusive situation?

In conclusion, rather than relying upon personal observations, myths, and stereotypes about the plight of battered women, the present study intends to investigate empirically the emotional and psychological consequences of battering. Its main purpose is to substantiate the common sense proposition that depression and anxiety are more frequent and intense among women who suffer from continuous stressful, violent,

and life-threatening circumstances. It is contended that escape from the danger zone--the home--and removal from these situations is apt to alleviate the anxiety and depression of battered women. Also, descriptive data on the nature of the abuse and the services most needed by the victims are presented.

Hypotheses

The following hypotheses will be tested:

1. The levels of depression and anxiety will be higher in the battered women group than in the non-battered women group. Stated differently, battered women are expected to suffer more intensely from depression and anxiety than their non-battered women counterparts.

2. While the degrees of depression and/or anxiety of battered women will decrease as a function of staying at the shelter, no substantial variations are expected in the non-battered women group.

3. There will be a positive correlation between specific dimensions of the battering experience and selected emotional states such that the higher the frequency, the more intense the severity and the longer the duration of the battering experience, the greater the extent of depression and/or anxiety.

Significance of the Study

The choice of studying depression and anxiety among battered women stems from the belief that these emotional/cognitive disorders may play a highly influential role in much of the behavior of the victims.

These variables are particularly significant because of their paralyzing effects on the emotional growth and development of the victims. Depression and anxiety may block the victims from taking an active stance in changing their plight, may reduce the number of alternatives they are willing to consider, and may further their entrapment and resignation to continue in destructive relationships. These emotional states may affect the frequency and/or the persistence in exerting efforts to seek professional and paraprofessional help. They can keep the victims from doing some things necessary for their survival and are certainly obstacles to their own autonomy.

The psychological aftereffects of battering were viewed as one of the major factors responsible for women staying in abusive homes. Physical, financial, and emotional dependency, fear, shock, guilt, depression, hopelessness, helplessness, humiliation, intense isolation, and an overall resulting low level of self-esteem are predominant emotional states which serve to keep the battered women immobilized both psychologically and behaviorally (Moore, 1979).

Beck (1976) describes the negative effects of anxiety as an interference with the capacity to deal with danger. This may increase one's vulnerability in a life-threatening situation. He indicated instances of "freezing" in the face of a physical threat. According to Beck, "Anxiety does not contribute to the adaptive sequence. When anxiety encroaches on coping behavior, it is likely to have a disruptive effect" (p. 135).

Prescott and Letko (1977) also criticize the dysfunctional and disruptive effects of depression. They write:

> Depression is accompanied by low emotional energy at a time when women may need this resource in order to deal with violence in their marriages. Depression can affect how frequently or how persistently women seek help directly from agencies or other helping groups. (p. 84)

Similarly, Hilberman and Munson (1977-78) describe the role that anxiety plays in the battered woman's life:

> The women were a study in paralyzing terror which is reminiscent of the rape syndrome except that the stress was unending and the threat of the next assault ever-present. . . . Agitation and anxiety boarding on panic were almost always present. "I feel like a pressure cooker ready to explode." "I feel like screaming and hollering, but I hold it in." They talked about being tense and nervous by which they meant "going to pieces" at any unexpected noise, voice, or happening. Events even remotely connected with violence, whether sirens, thunder, people arguing or a door slamming, elicited intense fear. . . . There was chronic apprehension of imminent doom, of something terrible always about to happen. . . . Sleep, when it came, brought no relief. Nightmares were universal. (p. 464)

It is important to recognize, acknowledge, and understand the presence and the weight of the various sorts of feelings. Repression and/or denial of these emotions may compound the problem and may impede the process of healing.

As previously indicated, another aspect of the study is related to the victims' experience at the shelter and their subjective evaluation of their personal needs. The importance of gathering firsthand information regarding the individualized subjective needs of women residents can serve as a tool for clarification of objectives and goals of shelters. Such information can help to modify, improve, and stress certain services over others. This information can also be used as a feedback to staff in order to refine and change certain aspects of the program if necessary. The researcher hopes that the questionnaires may become a potential tool for evaluation and continued improvement in the provision of services and shelter to battered women.

The importance of the current study also stems from the rarity of psychological research in this area. It has been indicated that the direct effects of marital violence on women have received little attention, although many women who need long-term support and help have been severely damaged by years of battering (Prescott & Letko, 1977).

This study is also important due to its empirical nature. Very few empirical tests have been made in the field of women abuse. As Stahly (1978) correctly observed, the theoretical explanations of the problem are more extensive than the empirical studies. Combining the theoretical with the empirical findings may contributed to further understanding of the psycho-social dynamics and consequences of domestic violence.

Finally, conducting ongoing research in the area of wife abuse may ensure that this issue does not become merely a passing fad, but becomes and remains a serious public problem which deserves the continuing concern and attention of public policy makers.

Definition of Terms

Battered woman or woman abuse or wife abuse--These terms are going to be used interchangeably. Battered woman is defined as a woman who had received deliberate, severe, and repeated demonstrable physical injury from her partner.

Domestic violence or violence in the family--For the purpose of this study, these concepts strictly refer to violence between mates. They do not include other forms of violence such as child abuse, abuse between siblings, etc.

Wives--This term is used in its broadest sense, and it refers to the social relationship between cohabitees. It is not restricted to women who are legally married. Wife includes any woman who lives together with a man.

Violence or abuse or battering--Interchangeably used concepts. The intent of this study is to focus explicitly upon violence which involves the use of physical force, which tends to result in bodily injury.

Depression--Beck (1967) defines depression as "an abnormal state of the organism manifested by signs and symptoms such as low subjective mood, pessimistic and nihilistic attitudes, loss of spontaneity and specific vegetative signs" (pp. 201-202).

A more detailed definition of the construct of depression includes the following attributes:

1. A specific alternation in mood: sadness, loneliness, apathy.
2. A negative self-concept associated with self-reproach and self-blame.
3. Regressive and self-punitive wishes: desires to escape, hide, or die.
4. Vegetative changes: anorexia, insomnia, loss of libido.
5. Changes in activity level: retardation or agitation. (Beck, 1973, p. 6)

State anxiety--(A-State) is conceptualized as a

> transitory emotional state or condition of the human organism that varies in intensity and fluctuates over time. This condition is characterized by subjective, conciously perceived feelings of tension and apprehension, and activation of the autonomic nervous system. Level of A-State should be high in circumstances that are perceived by an individual to be threatening, irrespective of the objective danger. A-State intensity should be low in nonstressful situations, or in circumstances in which an existing danger is not perceived as threatening. (Spielberger, 1972, p. 39)

Trait anxiety--(A-Trait) is defined as a

relatively stable individual differences in anxiety proneness, that is, the differences in the disposition to perceive a wide range of stimulus situations as dangerous or threatening, and in the tendency to respond to such threats with A-State reactions. A-Trait may also be regarded as reflecting individual differences in the frequency and the intensity with which A-State has been manifested in the past, and in the probability that such states will be experienced in the future. Persons who are high in A-Trait tend to perceive a larger number of situations as dangerous or threatening than persons who are low in A-Trait, and to respond to threatening situations with A-State elevations of greater intensity. (Spielberger, 1972, p. 39)

CHAPTER II
REVIEW OF THE LITERATURE

Theories of Domestic Violence

Gelles (1982) presented a condensed summary of the various theoretical models of family violence. He observed that this subject has been approached from three general levels of analysis: (1) the psychiatric model, (2) the social-psychological model, and (3) the sociological or sociocultural model.

The psychiatric model. This model conceptualizes violence as the product of some idiosyncratic, individual characteristics of the victim, assailant or the psychodynamics of their interactions. The model postulates that the couple has distinctive personality traits which are major determinants of violence. For instance, they describe the women as masochists and their men counterparts as sociopaths. Additionally, the model links mental illness, alcohol and drug abuse, and other intraindividual phenomena to acts of family violence (Gelles, 1982).

The social-psychological model. This approach focuses on the impact of external, environmental factors on the family. General theories such as learning theory, frustration-aggression theory, exchange theory, and attribution theory approach violence from the social-psychological level of analysis (Gelles & Straus, 1979).

The sociocultural or sociological model. This model deals with violence in light of the social structure of society, inequality, and

cultural attitudes and norms about violence and family relations (Gelles, 1982).

Within each of these three general theoretical approaches, there are several specific theories of family violence. Five selected theories will be presented briefly. The theories of learned helplessness and the cycle theory of violence were not covered by Gelles's paper. However, they are encompassed by the social-psychological model. The theory of patriarchy and the resource theory of intrafamily violence belongs to the sociocultural model. Finally, the female masochism hypothesis is an example of the psychiatric model of conceptualizing wife abuse.

Learned helplessness

Walker (1978, 1979) uses the psychological construct of learned helplessness as a rationale to explain why battered women become victims. The process of victimization is perpetuated to the pain of psychological paralysis which prevents them from leaving the abusive relationship. This concept was originally developed by Martin Seligman as a result of his empirical studies with animals and humans. His main point is that helplessness is learned and once it is learned, it saps the motivation to initiate a response that might alleviate present discomfort. He writes:

> When an organism has experienced trauma it cannot control, its motivation to respond in the face of later trauma wanes. Moreover, even if it does respond and the response succeeds in producing relief, it has trouble learning, perceiving and believing that the response worked. Finally, its emotional balance is disturbed; depression and anxiety, measured in various ways, predominate. (Ball & Wyman, 1977-78, p. 546)

Walker (1979) suggests that traditional sex role socialization can be responsible for the learned helplessness behavior seen in battered women. Throughout this process they learn that they have little direct control over their lives no matter what they do. There is a strong underlying assumption that no matter what they will do, nothing is going to change. They do not believe they can escape from the batterer's domination. They also don't believe that they can stop the batterer's violent behavior. Consequently, they cease all attempts to change their situation, giving up whatever power they may have and presenting a faulty picture of a successful marriage in order to live up to the illusional cultural stereotype of the "happy family."

Ball and Wyman (1977-78) believe that the theory of learned helplessness is one of the most relevant in understanding the plight of battered women. They see battered women as victims of over-socialization into a stereotypical feminine role. Dependency and passivity are major ingredients for the traditional feminine role. Internalization of these qualities interferes with the ability of battered women to make independent decisions, to choose and be responsible for choices. Ball and Wyman (1977-78) stated:

> . . . Having learned, all her life, to be dependent on others to meet her basic needs, she feels incapable of "making it on her own" even in the face of spending a lifetime with an abusive husband. . . . Furthermore, because the battered wife has no sense of control, she has no expectation of success if she were to try to take control. (pp. 597-598)

The authors indicated that the feeling of powerlessness is reinforced by the responses of relatives, neighbors, police, and social service agencies. They attribute this observation to, first, the common belief that the battered woman is probably getting what she deserves,

and, second, there is an unwillingness to interfere in an ongoing marriage. The woman is expected to work out her problems on her own, and it is her own responsibility to make her marriage successful and maintain it at all costs.

The cycle theory of violence

Walker (1979) discovered a definite battering cycle that battered women experience. This theory is proposed to provide an additional explanation for the process of victimization of battered women and why they stay in abusive relationships.

She describes the battering cycle as consisting of three distinct phases, which vary in both time and intensity for the same couple and between different couples. However, she does not have any information regarding the length of each phase nor the length of time required for the completion of the cycle. The three phases are the tension-building phase; the explosion or acute battering incident phase; and the calm, loving respite phase.

The tension-building stage. During this stage minor battering incidents occur. Battered women respond in different ways to prevent the batterer's escalation of anger. They also use defense mechanisms of denial and rationalization in order to minimize the harmfulness of battering incidents. They deny their anger by taking some of the blame on themselves and/or attributing the causes of the battering to external situations hoping that when this situation changes the batterer's behavior toward them will improve. Although they know that these minor battering incidents will escalate with time, they tend to deny this knowledge to help themselves cope. They also make themselves believe that

they have some control over the batterer's behavior. They religiously attempt to manipulate and control external factors which they perceive as possible provocation to a battering incident. Of course these attempts are futile and do not stop the batterer's behavior. However, as the tension builds, the minimal control they have is rapidly lost. Their anger increases steadily and they come across as passively accepting the abusive behavior, which can encourage the abusers not to have any control over their behavior.

The built-up tension becomes more frequent and severe. Both partners lose their previously functional coping techniques, and the tension becomes unbearable.

The acute battering incident. Walker (1979) characterized this stage as the unpredictable and uncontrollable major destructive discharge of the tensions that have built up during phase one. What distinguishes this phase from the first one is that both partners acknowledge its seriousness and accept the fact that the batterer's rage is out of control. It is important to note that the trigger for moving into phase two is rarely the battered woman's behavior; rather, it is usually an external event or the internal state of the man. Yet, occasionally the battered woman does provoke a phase-two explosive and inevitable incident in an attempt to put an end to her terror, anger, and anxiety. She expedites this process with the expectation that the third phase of calm and respite will follow the acute battering incident.

Kindness and contrite loving behavior. This is the third and last stage of the violent cycle. It is characterized by extremely loving, charming, kind, and contrite behavior by the batterer and an unusual period of calm. He sincerely expresses his regret for his

previous actions, begs forgiveness, and promises that he will never do it again. Walker (1979) observed dramatic change in the feelings of battered women who were hospitalized as a result of an acute battering incident. When they first come to the hospital they are lonely, angry, frightened, hurt, and realistically accept the fact that they are not able nor responsible for controlling the batterer's behavior. During their stay in the hospital, the batterer uses all his resources to make it up to her. He intensifies his visits and telephone calls. He sends her flowers, candy, cards, and other gifts in her hospital room. He engages significant others in their lives to call and plead his case. They all play on her guilt cords not to break up a home, the holiness of permanency of love and marriage, the kids' and his needs for her, and the destruction she will cause if she leaves. As a result of his loving behavior, social pressure, and her own adherence to traditional belief systems, the battered woman starts to feel happy, confident, and loving. She believes that he really can change and she will not suffer any more. She chooses to believe that the batterer's loving and caring behavior is more indicative of his true nature than the battering behavior. She also realizes during this phase his vulnerability, insecurity, and frailty. She senses his desperation, loneliness, needs, and alienation from others. He threatens to commit suicide, and she feels responsible for his emotional well-being. Therefore, their relationsihp can at best be described as symbiotic. Both are overly dependent upon each other to the extent of being paralyzed when it comes to terminating their relationship. It is also in this phase where it becomes extremely difficult for the woman to make a decision to end the relationship since this is almost the only time she gets all the rewards associated with being

married. Knowing that she has traded her psychological and physical safety for these temporary rewards contributes to self-hatred, embarrassment, and shame.

Walker (1979) contends that the exact length of time of this stage is not yet determined. Most women in her research report that before they know it, the calm behavior gives way to little battering incidents and a new cycle of battering behavior begins.

Patriarchy and Wife Abuse

Gelles (1982) considers the theory of Dobash and Dobash (1979) as the most macro-level approach to wife abuse. They emphasize specifically the unique phenomenon of women's abuse contrary to many other theories that were developed to explain family violence in general. They try to make the point that women are almost always the victims of family violence whether they are the wives, sisters, or daughters. They criticize researchers for ignoring the historical and empirical fact that violence is not randomly distributed among family members, but it is disproportionately directed toward females. Statistical evidence indicates time and again that women are much more likely to be the victims of domestic violence. The Dobashes' (1978) findings clearly support this thesis. Husbands are only rarely assaulted by their wives (1.1%), whereas attacks on wives represent over 75% of all violence in the family setting. These findings are consistent with other research data which support the notion that women are the "appropriate" victims of marital violence (Chester & Streather, 1972; Levinger, 1966; Lystad, 1975; McClintock, 1963; O'Brien, 1971).

The Dobashes' focal theoretical point of argument is that the predominance of violence directed at women is perceived to be essentially as a means to establish or maintain a patriarchal social order. The violent practice is used to reaffirm and maintain a hierarchical and moral order within the family whereby the male asserts his domination, control, and chastisement of women. Patriarchy, hierarchy, and subordination of women in marriage are all deeply rooted in the legal, religious, political, economic, and cultural legacies which have contributed to a historical pattern of systematic violence directed against women. The Dobashes' article provides evidence from diverse sources to document the prevalence of violence directed at wives in contemporary societies. They analyzed systematically 33,724 police and court records and interviewed battered women in depth. They also presented historical background of the legacy of patriarchy and the development of the different laws of chastisement since the Middle Ages. The crux of their theoretical orientation is a view of violence against women in a wider sociohistorical context rather than a focus solely upon individuals or couples involved in violent relationships.

Resource Theory of Intrafamily Violence

Goode's theory (1971) was the first theoretical approach applied explicitly to violence in the family (Gelles, 1982). He conceptualizes the family as a power system which rests to some degree on force or its threat. He asserts that force--which emerges into violence and takes different forms such as assault, murder, child abuse, wife abuse, etc.--is one of the resources that can be used to maintain or advance individual or collective interests. Essentially violence is used as the

last resort when all other resources are not effective or available. Goode posits that within a social system--family in this case--the greater the resources a person can command, the more forces he can muster. However, the more resources a person can command, the less that person will actually deploy violence in an overt manner. Applying these assumptions to the family, Goode acknowledges the fact that the member with the greater strength and willingness to use it--this is usually the father--commands more force than others do. He argues that family processes create many patterns that ultimately generate violence. He writes:

> They inculcate the evaluations that make people want to force others to act in certain ways even at the risk of danger; they present models of the use of force and violence; they teach the various gradations of violence for different occasions; and they teach a set of rationalizations and justifications for violence. (Goode, 1971, p. 631)

He contends that both the victim and the attacker contribute to violent outcomes through the ongoing actions and counteractions of their daily lives. He also assumes that almost everyone is capable of violence and that almost every family member is from time to time enraged to murderous impulses by other family members. Therefore, he suggests an examination of family dynamics that generate such responses. He proposes an exchange perspective to explain the dynamics of violent marital relationships. Essentially, this perspective asserts that interaction in marriage is governed by partners seeking to maximize rewards and minimize costs in their exchange relations, that they expect rewards to be proportional to investments ("distributive justice"). Consequently, when the principle of distributive justice is violated, the growth of resentment, anger, and hostility is noticed. The dynamic that one or

both sides feel cheated in the flow of family exchanges and their belief that they are already paying out more than they should be may lead to hostile and hurtful attacks and counterattacks. The couple's emotional closeness and their keen knowledge of the other's weaknesses contribute to escalating conflicts which take the form of vicious physical or psychological fights. In Goode's (1969) own words:

> Locked in but suffering from it, couples may engage in fighting that is savage and even lethal. Many men and women have finally come to the conclusion that homicide is a cleaner, neater solution than the dragged out acerbic destruction of ego and dignity that is inherent in breaking off. (p. 958)

The Female Masochism Hypothesis

The psychoanalytic concept of masochism has been used to explain female behavior. It suggests that suffering for women is inherently bound up with erotic pleasure and is desired for that reason (Waites, 1978). This term also implies an unconscious desire or need for suffering (Rounsaville, 1978). Snell et al. (1964) concluded that masochism appeared to be the salient concept in their understanding of the behavior of the wives they studied. They see the husband's aggressive behavior as filling masochistic needs of the wife and as necessary for the wife's and the couple's equilibrium. Additionally, they describe the men in their study as aggressive, efficient, masculine and sexually ineffectual, reasonably hard-working "mother's boys" with a tendency to drink excessively, and with strong dependency needs.

Masochism has often been employed as an explanation of one of the frequently asked questions: "Why don't they leave?" However, many recent writers refute masochism as an explanation for staying in an abusive relationship (Martin, 1976; Walker, 1979; Waites, 1978; Pizzey,

1974). They cite the objective obstacles facing a battered woman who attempts to improve her lot.

Rounsaville (1978) has empirically examined the masochism hypothesis. His concluding remarks are that there is little evidence that would suggest either that the women wish to bring the abuse onto themselves or simply that they are trapped in their homes without options. The results of his study indicate that few had a prior history of overtly violent relationships. The only self-destructive behavior reported is that the majority of the women admit to occasionally escalating the fights. The women were not passively accepting the abuse, as most had attempted to get some sort of help; but things did not change. Rounsaville provides three alternative explanations to why battered women remain in such relationships. First, the women feel the cost of leaving is greater than the cost of staying. Second, they are staying in spite of the abuse or because of the positive aspects of the relationship and the intermittent nature of the abuse. Finally, although the women do have options, they don't feel that they do.

This brief presentation of the diverse theoretical perspectives is an indication of the extremely complex problem of woman battering. Given the overlap of so many theories, Walker (1980) proposes a multideterministic theoretical orientation for explaining causality of woman battering. After reviewing over 160 theoretical and incidence studies, Lystad (1975) arrived at a similar conclusion. He believed that a comprehensive theory of domestic violence must take into account factors at the psychological, social, and cultural levels.

Commonality of Wife Beating

Writers have consistently revealed that the family is the most frequent single locus for violence of all types (Gelles & Straus, 1975; Gelles, 1974; Martin, 1976). However, research on family violence was limited to child abuse and murder. Wife-beating, until recently, was a neglected social phenomenon and received inadequate recognition. Dobash and Dobash (1978) have observed that researchers often fail to note that this violence is not evenly distributed among family members, but is disproportionately directed toward women. Female victims of homicide are more often killed by a spouse, while the majority of male victims are killed by someone outside the family. According to Dobash and Dobash (1978), about 40% of all female homicide victims were killed by husbands, but only 10% of male victims were killed by wives. It has also been reported that among those who murder spouses, wives were seven times more likely than husbands to murder in self-defense (Hilberman, 1980). According to the FBI, nationwide in 1973, one-fourth of all murders occurred within the family, and one-half of these were husband-wife killings (Martin, 1976).

Estimates of the number of battered wives vary widely. Langley and Levy (1977) indicated that the simple truth is that no one knows how many American women are being routinely beaten by their husbands, ex-husbands, boyfriends, common-law spouses, and dates. A number of researchers have attempted to find this information. Eisenberg and Micklow (1977) reported that no national or state statistics are available on the incidence of wife assault crimes. This "selective inattention" to the rates of wife-beating was documented by O'Brien's finding (1974) that the index of the Journal of Marriage and the Family from its

inception in 1939 through 1969 contained no references to "violence." Steinmetz and Straus (1974) criticized the nonexistence of any study giving figures for a representative sample of the percentage of couples who get into violent fights. Yet, they observed that almost every other aspect of family life has been the object of many studies by social scientists. Straus (1974) conducted a survey consisting of 385 college students. Results showed that 16% of the sample reported that their parents had been physically violent toward one another during the past year.

Steinmetz (1977b) reported the findings of a randomly selected sample of 57 intact families from New Castle County (Delaware). Her results show that over 60% of all families participating in the study experienced some form of marital violence during their marriages. Seven percent of the wives suffered severe and repetitive beatings.

Gelles (1974) studied 80 families in New Hampshire. Forty were identified by the police and social agencies as likely candidates for violence, and the remaining 40 were neighbors with no history of violence. This second group was supposed to serve as a nonviolent control group with which the violent group could be compared. The results showed that 44 families--55%--engaged in one or more violent acts of spouse assault. Twenty-one percent beat their spouses regularly. The frequency of these beatings ranged from daily to six times a year. But Gelles's most unexpected finding was in the control group. Of these supposedly nonviolent families, 30% had experienced at least one incidence of violence and for 12%, violence was a regular occurrence.

Straus (1977-78) presented the results of a nationwide study of over 2,000 couples representative of all American couples regarding the

extent of wife-beating and its causes. His findings revealed that in any one year approximately 1.8 million wives are beaten by their husbands. He also indicated that nearly 30% of all couples reported experiencing a violent incident at least once in their marriage. Straus regards these figures as underestimates and suggests that the actual incidence rate runs closer to 50 or 60% of all married couples. Estimates that 50% of all American wives are battered are very common. Walker (1979) estimates that 1 out of 2 women will be battered in their lifetime. She also discusses the issue of underreporting of battering and estimates that only 1 in 10 battered women does report battering assaults. The FBI estimates that the number of wife beatings reported in this country is three times higher than the number of rapes reported, and there is a rape reported every 3 minutes. In addition, the FBI estimates that this is less than 10% of the total number that occur in this country and are not reported (Martin, 1976).

Several theoretical and experimental suggestions have been provided to explain the underreporting problem. Steinmetz (1977b) stated three reasons for the gross underreporting of wife assaults: first, personal guilt felt by women who experience beatings; second, inability to safely report the incident; finally, lack of protection given to women who do seek police and legal methods to end abuse. It was also indicated that because of the stigma attached to victimization by spouses, women who are assaulted are usually ashamed and/or afraid of speaking out (Joint Strategy and Action Committee, Inc., 1977).

Straus (1978) questions the accuracy of his research findings in which 28% of all couples in his sample were willing to describe violent

acts in a mass interview survey. His doubts stem from the following reasons:

1. Underreporting of domestic violence is likely to occur among those for whom violence is so much a normal part of the family system that a slap, push, or shove is not a noteworthy or dramatic enough event to be remembered.

2. Those who experience severe violent acts are likely to show some reluctance to admit such acts because of the shame involved if one is the victim, or the guilt if one is the attacker.

3. A final reason for regarding these figures as underestimates lies in the nature of the sample. Only couples living together were sampled. Divorced persons were asked about the current marriage. Since excessive violence is a major cause of divorce, these data probably omit many of the high violence cases. Divorce statistics are an additional source of information which indicate the prevailing phenomenon of wife battering. Levinger (1966) found that of 600 applicants for divorce in the Cleveland area, 36.8% reported that physical abuse was one of their complaints and was the reason for ending the marriage. Among the violent couples, 48% revealed that the violence had been chronically recurring throughout the marriage. A Wayne County (Michigan) judge stated that approximately 16,000 divorces are initiated in this country annually and in 80% of those coming before him, beating is alleged (Martin, 1976). A New York City attorney reports that of 500 women represented in divorce actions in Brooklyn in 1976, 57.4% complained of physical assaults by their husbands (Walker, 1979).

Police records, although probably underreported, give some indication of the problem. In Chicago, a police survey demonstrated that 46.1% of all major crimes, except murder, perpetrated against women took place in the home. The study also revealed that police response to domestic disturnce calls exceeded total response to murder, rape, aggravated assault, and other serious crimes (Martin, 1976). Records in Fairfax County, Virginia, show more than 4,000 family disturbance calls per year. Over half of these calls involve husbands beating wives. It is also reported that these statistics are underestimates, probably because 40% of the daily fights are not recognized as such on police records (Langley & Levy, 1977). However, these statistics are not surprising in a culture where violence in the family is perceived as normal, legitimate, instrumental, and socially condoned (Gelles, 1974; Gelles & Straus, 1975; Steinmetz & Straus, 1974). That violence between spouses is an accepted conduct is reflected in results of the 1968 interview survey conducted for the National Commission on Causes and Prevention of Violence. This survey, consisting of 1,176 interviews with a representative national sample of American adults, showed that 20% approved of slapping one's spouse on "appropriate" occasions (Stark & McEvoy, 1970).

This brief summary of literature review shows clearly that there is strong empirical evidence advocating the high frequency of women battering.

Spouse Abuse and Selected Demographic Variables: Class and Race

Some researchers as well as experienced clinicians in this area have attempted to refute common myths, misconceptions, and stereotypes

about the characteristics of battered women. Butler (1981) outlined eight erroneous attitudes regarding battered women. One of them is that battering occurs only within low-income or working-class families, or within particular racial or ethnic groups. Butler stated that women from every kind of racial, social, ethnic, and economic background have been battered. She attributes the popularity of this belief to the source of statistics, which are usually derived from public agencies, which, in turn, constitute the only available resources to battered women from certain classses and races. Middle- and upper-middle-class women are more likely to have other options open to them, and they do not have to rely heavily on the assistance of social services.

The first myth is that middle-class women do not get battered as frequently or as violently as do poorer women. She contends that, as a result of increased publicity about battered women, more middle- and upper-class women are coming out of hiding. The second myth postulates that women from different cultural backgrounds experience dissimilar responses to battering. This myth is also negated by Walker's research findings. She interviewed Anglo, Black, Asian, Pacific-American, and Native-American battered women. In spite of the racial/cultural differences, she found that battering stories were similar. These women experienced similar embarrassment, guilt, and the inability to halt their men's assaults. The main difference between Anglo and non-Anglo women was that there are limited resources available to minority women.

Stark and McEvoy's (1970) analysis of survey data on the approval of slapping one's spouse on appropriate occasions indicated that 16% of those with 8 years of schooling or less approved and 25% of

the college-educated people approved of a husband slapping his wife. Further analysis of the data showed that 25% of the blacks, 20% of the whites, 25% of the males, and 16% of the females interviewed approved of a husband's slapping his wife's face. They also found that those with incomes of $5,000 or less were considerably less approving than those in other income brackets. Subjects under 30 years old were most approving, and those 65 years or older were least approving of husband-wife slappings.

Martin (1976) also stated that battering occurs among all classes and provided statistical data to support her argument. She first considered the assumption that marital violence is more frequent among lower-class families. This is a reflection of middle-class investigators' inability to face the universality of the problem. She presented the following examples which were derived from different studies:

- Police in Fairfax County, Virginia, which is considered to be one of the wealthiest counties in the United States, received 4,073 family disturbance calls in 1974. They estimated that 30 assault warrants are sought by Fairfax County wives each week.
- The number of wife-abuse cases reported in New York's 30th Precinct--a socially stable community in West Harlem consisting mostly of working-class Blacks, 8% Latin Americans, and 2% whites--was roughly the same as that reported in Norwalk, Connecticut--a white upper-middle-class area with approximately the same size population.

A report prepared by the National League of Cities and the United States Conference of Mayors notes:

> The incidence of wife assault is so pervasive in this society that half of all wives will experience some form of spouse-inflicted violence during their marriage, regardless of race or socio-economic status. (Langley & Levy, 1977, p. 20)
>
> Police records indicate that wife beating occurs in the suburbs as well as in the ghettos. For example, in Washington, D.C., between 5,500 and 7,200 husband-wife assaults are reported every year. The explanation was that the District of Columbia is highly populated by Blacks, many of whom are poor and living in crowded, wretched conditions that lead to subhuman behavior. However, in Montgomery County, Maryland, one of the wealthiest suburbs in the nation, official figures show police responded to 4,225 cases of "family trouble" including 285 verified assaults by husbands on wives. (Langley & Levy, 1977, p. 22)

Schulman's (1979) survey of wife abuse in Kentucky found that income levels were not good predictors of family violence. School dropouts with less than an eighth-grade education appeared to be less violence-prone than those who had some college education.

Hilberman (1980) believes that spouse abuse is not limited to a particular social class or ethnic group, although the highest reported incidence is among the poor. He argues that poor people are more likely to come to the attention of a public agency, while the privacy of middle- and upper-class women is protected by their personal physicians or attorneys.

Nisonoff and Bitman's (1979) survey of 297 residents of Suffolk County, a suburban, middle-to-upper-class community in Long Island, revealed that approximately half the respondents reported knowing one or more persons who had been hit by his or her spouse. Overall, 25% of the men and 16.5% of the women reported having hit or been hit by their mates. The researchers failed to find a negative correlation between

occupational status and frequency of spouse abuse. Contrary to their hypothesis, homemakers were not more frequently the victims of spouse abuse. Also, there was no trend for less-educated women to report more frequently having been abused.

In examining the relationship between social structure and family violence, Gelles's (1974) findings reveal that violence is the most common in families who have low education, low income, and low occupational status. Generally, the relationship between the measures of social position and family violence are inverse relations. The exceptions are the relationship between occupational status and violence and the measures of the wife's social position (education, occupational status) and conjugal violence.

His data on the husband's occupational status and conjugal violence produce an inverted U-shape curve rather than the plot found for education and income. It is indicated that violence is not the most common among those husbands who are unemployed, rather it is the highest among families where the husband has a medium-status job.

Komarovsky (1967) has also found an inverse relationship between education and family violence. His data reveal that violent quarrels were mentioned as a mode of conflict by 27% of the husbands with under 12 years of school and by 17% of husbands with 12 years. For wives, 33% with under 12 years' education mentioned violence, while only 4% with 12 years' education discussed violent quarrels.

Prescott and Letko's (1977) results point to the importance of economic factors as contributors of marital disputes. They indicated that men who were only employed part-time or were unemployed at the time

of the most recent conflict were more violent toward their wives than men who were employed. Researchers also noticed that husbands who experienced low job satisfaction were more likely to punch or kick their wives than husbands who were satisfied with their jobs. Seventy-three percent of those women whose husbands were described as having low job satisfaction were punched or kicked, while only half of the women whose husbands were satisfied with their jobs were treated in this way. They also reported that, for most women, the most recent instance of violence occurred between 1970 and 1975, a period of rising unemployment and job insecurity. Marital violence was also reported to increase during a period of unemployment in British history.

Their findings demonstrated the importance of financial strain in relation to marital violence. Women who reported financial problems to be moderate or very severe were more often assaulted with weapons than those with limited or no financial worries.

Gelles (1982) reviewed the literature on the relationship between wife abuse and socioeconomic status. He observed that the picture of this relationship is ambiguous. He noted that there is empirical evidence supporting the hypothesis that wife abuse is more prevalent in low socioeconomic status families. However, he believes that this conclusion does not mean that domestic violence is confined to lower-class households and it can be found in families across the spectrum of socioeconomic status.

In the same article, Gelles concluded that examinations of the relationship between race and family violence have yielded mixed results. Byrd's (1979) review of research on interpersonal violence

revealed that race was not related to intersexual assault in the home. On the other hand, data from the national survey of family violence (Straus et al., 1980) indicate that rates of abusive violence among couples, toward wives, and toward husbands were higher in Black than in white families. Black couples reported a rate of abusive violence more than double the rate for white (11% as opposed to 5%). Black males were more than three times more abusive toward their wives than white males (11% as opposed to 3%).

Although it is clear that wife abuse cuts across all lines of class and race, Fleming (1979) has found that there are significant differences between the experiences of battered women from low-income communities and abused women from middle-class suburban areas. She pointed out two main differences: first, the tendency for low-income women to fight back on a physical level; another area of difference is the availability and utilization of resources. She noted that middle-class women have more resources, yet they tend to use them less. Fleming stated several reasons to explain her observation. They are as follows:

1. Middle-class women are controlled by shame and embarrassment.

2. They are more likely to protect their husbands, due to their anxiety about harming their careers, which represents their means for survival.

3. They are less likely to be believed when and if they attempt to let others know what is going on or to seek help.

4. Many programs will base eligibility for service on the husband's income, even though the woman herself may be penniless.

5. They are more frightened of the prospect of leaving the husband, particularly if they have never lived independently.

6. If the husband is influential in the community, the wife may find herself unable to obtain a good lawyer, a decent job, or sympathetic medical care.

Although the resources of the low-income woman are fewer, she will use them more. She is more knowledgeable of the different social services. Also, due to fostered independence, she is more likely to take concrete actions in her own behalf. She has more difficulty in relying on family members for assistance, since they are less likely to have the financial resources to help her (Fleming, 1979).

Psychological and Psychiatric Research on Wife Abuse

Hilberman (1980) noted that the sociological and feminist literature on this topic has expanded rapidly in the last decade; however, the clinical and psychiatric literature is relatively new and is often found outside traditional sources.

It is also noticeable that psychologists and psychiatrists focus mainly on describing the personality traits and mental health states of the victims, of their batterers, or both. Usually, they tend to diagnose them as psychopathological individuals. However, there is an exception to this overgeneralization. Recently, researchers shifted their attention from focusing on the psychological, individual, and pathological aspects of the problem to providing social, cultural, and structural explanations to it (Couch, 1983).

Some clinicians also refrain from ascribing labels to the battered woman or her abuser. For example, Goodstein and Page (1981) believe that the battered women syndrome is not a diagnostic category unto itself, but rather cuts across a wide spectrum of underlying diagnostic categories and personalities.

Scott (1974) stated that wife beating at best can be conceptualized as a failure of adaptation rather than as a pathological condition in the husband which must be cured or eradicated. Moreover, the author pointed out that in the present state of knowledge, there is no clarity as to the nature of the relationship between mental illness and wife battering. It is not clear yet what comes first. Does the mental illness cause the battering or vice versa? Although Scott acknowledges the presence of some personality factors in the dynamics of conjugal violence, he is not willing to provide a definite psychiatric explanation of what may be largely a sociological phenomenon.

Personality Profile

"Who is the battered woman? What kind of woman is she?" are very frequently asked questions. The answers are controversial. They can be classified into two major categories:

1. One group of researchers believes that there is no particular profile which differentiates battered from non-battered women, since any woman can be the victim of abuse at one point or another.

2. In contrast to the first viewpoint, other researchers agree that most battered women share certain personality traits which increase the likelihood of their becoming trapped in violent relationships.

In this section a detailed description of the battered women syndrome will be presented. It is based on either empirical research findings or on the personal and clinical observations of the writers.

Hartik's (1982) study identified specific personality traits and self-concept factors which distinguished battered wives from a control group of non-battered wives. She used the 16PF and the Tennessee Self-Concept Scales as psychodiagnostic tools. Her study reveals the following results:

1. Battered wives fall at the lower limits of ego strength, whereas non-battered wives fall at the middle or average range of the Sixteen Personality Factor profile. This means that battered women are affected by feelings, emotionally less stable, easily upset, and changeable.

2. The two groups maintain approximately the same average range on superego strength on the 16PF.

3. Battered wives score significantly higher than non-battered wives on the Apprehensive characteristic of the 16PF. This is indicative of guilt proneness, apprehension, self-reproachment, insecurity, worrying, and being generally troubled.

4. Battered wives scored significantly lower than non-battered wives in Undisciplined Self-Conflict and Integration on the 16PF, indicating low self-sentiment integration, a tendency to be uncontrolled and lax following own urges, and carelessness of social rules.

5. Battered wives showed higher ergic tension than non-battered wives; they were frustrated, driven, overwrought, fretful. Their "id" energy was misdirected or converted into psychosomatic disturbances.

6. Battered wives show lower self-esteem and more difficulty with basic identity than non-battered wives on the Tennessee Self-Concept Scale.

7. Battered wives were less satisfied with themselves in terms of their behavior, physical self, moral-ethical self, family self, social self, and have more difficulty maintaining minimal self-esteem than non-battered wives.

8. Battered wives are generally more maladjusted, with overall less integration of personality than non-battered wives.

Hofeller (1982) selectively reviewed personality factors which characterize battered women. She noticed that many battered women tend to hold stereotyped attitudes regarding appropriate sex-roles. They often view men as superior and women as inferior. They tend to have very low self-esteem. They tend to cope with anger by either denying it or by turning it inward, resulting in depression, psychosomatic illness, and feelings of guilt. However, Hofeller reminds us that not all abused wives are totally meek and submissive; some women report resorting to violent encounters with their abusers.

Hofeller (1983) presents the following four common factors which tend to describe battered women: (1) low self-esteem, (2) adherence to traditional sex-role models, (3) inability to deal with anger, and (4) lack of self-nurturance.

Walker (1979) outlined common characteristics of battered women whom she has interviewed for her study. The respondents were a mixed group representing all ages, races, religions, educational levels,

cultures, and socioeconomic groups. However, they shared the following profile:

1) has low self-esteem
2) believes all the myths about battering relationships
3) is a traditionalist about the home, strongly believes in family unity and the prescribed feminine sex-role stereotype
4) Accepts responsibility for the batterer's actions
5) Suffers from guilt, yet denies the terror and anger she feels
6) Presents a passive face to the world but has the strength to manipulate her environment enough to prevent further violence and being killed
7) Has severe stress reactions, with psychophysiological complaints
8) Uses sex as a way to establish intimacy
9) Believes that no one will be able to help her resolve her predicament except herself (Walker, 1979, p. 36)

Carlson (1977) studied 260 female victims over an 18-month period. She found the following common traits among the victims: (1) they suffered from extremely low self-esteem, (2) they felt socially isolated, (3) they had an intense attachment to their children.

Many researchers and clinicians seem to agree about the battered women's tendency to adopt traditional and stereotypical attitudes regarding sex-roles. Davidson (1978) describes the battered woman's perception of her role as a wife. She writes:

> The victims may exemplify society's old image of ideal womanhood--submissive, religious, nonassertive, accepting of whatever the husband's life brings. They may exercise no independence of income, ideas, or movement, be anxious about housekeeping, and develop devotion to home and family to the exclusion of outside friends and interests. The husband comes first to these women, who perceive themselves as having little control over many areas of their own lives.
>
> They are meek, their reaction to their predicament is cowering and submission, not retaliation or action. They are the ones whose marriages are lived in fear, trying to please and appease, terrified of inadvertently making the wrong move. All their energies go into making the relationship survive with as little violence as possible.
>
> Marriage is important to them. Outward appearances are important, too. . . . keeping the image of a socially and religiously acceptable marriage takes priority over the possible consequences of exposure. . . . She grew up to believe that marriage and husband

> were what life was about, and that it was up to her to make her marriage work. She wants "everything to be all right again." But since that now seems impossible, she cannot think of other alternatives. (pp. 51-52)

Moore (1979) describes salient features of the battered woman. She stated that her profile looks almost identical to that of her batterer:

> She is all ages, all ethnicities, from all socioeconomic groups, has a low level of self-esteem, and for the most part has very traditional notions of male and female behavior. She may feel that her husband is supposed to be in charge of the family, even if that means beating her; she must be supportive of him, even if that means allowing herself to be abused repeatedly. Her role as a woman includes marriage, even a bad marriage and to leave the home would be to admit that she is a failure as a woman. (p. 20)

Star's (1978) study reveals the following personality profile of the battered woman:

> The overall profile depicts women with low self-esteem, a lack of self-confidence, and a tendency to withdraw. The women displayed an aloof quality, a critical or uncompromising attitude, and a sense of discomfort when interacting with others. The combination of shyness and reserve generally reflects traits developed in childhood as a result of poor early life relationships. The women are also anxious and have trouble binding their anxiety. The test results reveal an emotionality or sensitivity that leaves them feeling easily hurt, frustrated, perturbed, and overwhelmed. (p. 10)

In another paper dealing with the psychological profile of the abused woman, Star et al. (1979) came up with the following conclusions:

1. The personality tests used in their study showed that the battered women fell solidly within the average range of most of the personality and clinical factors. The battered women were of normal intelligence and comparable to the norms on the traits of dominance, enthusiasm, social awareness, self-reproach, and conservatism.

2. None of their findings is indicative of a clinical deviant population, yet there are some features that distinguish them from a random sample of women.

4. Women's difficulties in coping with their anxiety may be a resultant of immaturity, lack of clear self-identity, and early emotional deprivation in family of origin.

Ball (1977) described the women in her study as bewildered and helpless. They were very dependent with feelings of low self-esteem. They identified with their marital role and were unable to contemplate leaving.

Morgan (1982) concluded that the following characteristics seem to recur in studies of the battered woman profile: (1) battered women have extremely low self-esteem, (2) they feel responsible for the violence in many cases, (3) they have learned to be helpless and unable to do things for themselves, (4) they are socially isolated, (5) they are a diverse group whose problems are complex and deep seated.

Although Bowen (1982) agrees with researchers and clinicians that there is no such thing as a "typical" battered woman, she noted some common characteristics found in the literature to describe battered women. These are (1) low self-esteem, (2) dependency, (3) learned helplessness, (4) fear, and (5) psychological neediness.

Wetzel and Ross (1983) draw the profile of the battered woman based on their professional experiences in helping victims of violence. They indicate that their attempt to outline a closely approximating profile, rather than a precise one, is based on their assumption that virtually any woman can be the victim of domestic violence. However, they noted that the following characteristics appear more frequently in battered women than in the population as a whole:

1) Accepts traditional male and female roles
2) Is passive and placating, easily dominated
3) Accepts male dominance and the myth of male superiority
4) Equates dominance with masculinity
5) Feels she has no basic human rights--often not even the right not to be hit
6) Accepts guilt even where there has been no wrongdoing
7) Accepts partner's reality
8) Feels that she must help her mate
9) Acts as a buffer between her partner and the rest of the world
10) Has strong need to be needed
11) Underestimates or downplays the dangerousness of her situation
12) Has unshakable faith that things will improve or that there is absolutely nothing she can do about her situation
13) Bases feelings of self-worth on her ability to "catch" and hold a man
14) Suffers low self-esteem
15) Doubts her own sanity (p. 425)

Gellen et al. (1984) compared the personality profiles of 10 abused and 10 non-abused women by administering the Minnesota Multiphasic Personality Inventory (MMPI) to both groups. They found marked differences between the two groups on 8 of the 10 clinical scales. Battered women showed greater signs of personality disorders and pathological conditions. The two groups did not differ in terms of the hypomania dimension or in their perception of the female role. Unlike the researchers' expectation, abused women did not view themselves as traditionally female (i.e., helpless, dependent, and illogical).

Rounsaville et al. (1979) drew the following profile of abused women and made some practical treatment recommendations and guidelines:

1. Socially isolated, they will perceive themselves as stigmatized and of low status and worth.

2. They are likely to see psychiatric treatment as further stigmatization.

3. Most are depressed and therefore feel ashamed and fearful that their needs will not be met. Some need pharmacotherapy.

4. They have a tendency to use denial as a defense and likely to attend sessions intermittently at first, thinking that their problems are solved.

5. They find pressure to leave their partners threatening, despite their initial strong statements that this is their intention.

6. They are likely to view themselves as personally responsible for their partners' violent tendencies and the social stress that contributes to them.

7. They are likely to underestimate their strength and resources and are likely to be highly dependent.

8. They are fearful of retaliation by their partners.

9. They are likely to have limited financial resources. They might consider payment of even a small amount a burden, especially if they want to keep the therapy secret from their partners.

10. Practical advice may be needed concerning police, legal services, welfare services, jobs, and shelter.

Hofeller (1982) voiced her concerns regarding the nature of the relationship between personality traits and conjugal violence. Although she recognizes the presence of certain association between personality factors and wife beating, she suggests that the findings should not be accepted at face value because of two reasons: first, data in the above-mentioned subject tend to be primarily anecdotal; very few studies describe how the information had been obtained (i.e., whether or not a specific instrument had been used in personality assessment). Second,

personality factors cannot be viewed as causal; information about individual traits and role perceptions was obtained after or during the experience with abuse, never before the violence began. Also, the sample is apparently biased by the fact that only women who are still with their husbands were studied.

Other Relevant Research

In a study conducted by Dewsbury (1975), 15 battered wives were identified by five general practitioners over a period of 1 year. The subjects came from a modestly middle-class suburb of a Midland city in England. The women were described as disturbed or distressed and their "illness" fell under a variety of psychiatric diagnoses. It was reported that a third of the patients showed gross personality disorders (psychopathy, inadequacy, and "drop-out"). A further third showed neurotic reactions of reactive depression and phobic anxiety. Two wives had had previous experience of drug abuse. One woman showed a manic depressive psychosis. Dewsbury indicated that these women were frequently admitted to mental hospitals, and three had electroconvulsive therapy.

Although the researcher acknowledged the difficulty in gaining cooperation from the man for detailed case studies, he reported the following results regarding the nine husbands who participated in his research. He indicated that the husbands did not suffer from major mental illness. Their overall picture was of personality difficulties, often aggravated by physical causes, especially alcohol. Jealousy of morbid proportions, an irritable and aggressive temperament, and ritual sadism were specific personality disorders that were found to describe

these husbands. Alcohol was frequently associated with assaults, and minimal brain damage was witnessed in one case.

Any generalizations must remain speculative due to the methodological limitations of this study. These shortcomings are (1) the number of the subjects is small, (2) the sample was derived from a limited population, (3) results were obtained from the patients' records and from the author's personal knowledge of most of the subjects without validating or amplifying the data.

A psychiatric evaluation of victims of marital violence and their offenders was obtained by Gayford (1975a, 1975b). He interviewed 100 battered wives who came mostly from the Chiswick Women's Aid Hostel in England. The ages varied from 20 to 60, with an average age of 30 for wives and 33 for husbands. The majority of these women frequently visited their general practitioner, and 71 were taking antidepressants or tranquilizers. A psychiatric opinion was sought for 46 wives, and 21 were told that they were depressed and were treated with either physical or chemical agents. Suicidal attempts occurred frequently and were made by 41%. Many visited casualty departments with their injuries. Rarely the true diagnosis emerged. Twenty-three of the women and 51 of their husbands were exposed to family violence in their childhoods. There was a high incidence of drunkenness and previous imprisonment among the husbands. Gambling was recorded for 26% of men, and unemployment was a regular feature in 29 families. The husbands are pictured as men with low frustration tolerance, who completely lose control under the influence of alcohol, punch and kick their wives in a savage manner, perhaps using weapons to aid their assault. Women reported signs of morbid jealousy in 66% of their men. The author, however, was unable to

identify any class, educational, or economic predictors of abuse among the group. He indicated that both husbands and wives had a wide range of educational achievements.

On a survey of the 560 local Citizens Advice Bureaus in England, Jobling (1974) reported that subjects were largely lower SES and husbands seemed to batter their wives as a response to situational pressures. The women were characterized as generally submissive and passive, which Jobling suggests might in itself be provocative.

One of the best-known reports which describes the personality flaws of the victims and their husbands is the Snell et al. (1964) study "The Wifebeater's Wife." The article was written by three psychiatrists who were assigned to evaluate and possibly treat 37 wife beaters. These men were referred by a court which is known to serve a predominantly middle-class suburban area. Soon after starting to interview the couples, the authors noticed that the wives were much more willing to talk and "give their side of the story." While the men were usually "resistive to psychiatric contact, tending to deny that problems existed in their marriages which require outside help" (p. 108). Consequently, their sample included 12 of these couples who were interviewed for three or more times. Four of the wives have been worked with in long-term individual dynamically oriented therapy.

The authors commented that the salient concept which describes the behavior of the wives is that of masochism. They see the husband's aggressive behavior as "filling masochistic needs of the wife and to be necessary for the wife's (and the couple's) equilibrium" (1964, p. 110). The wives were diagnosed as aggressive, masculine, frigid, masochistic, efficient, overprotective of their sons, and emotionally deprived

people. On the other hand, husbands were characterized as passive, shy, dependent, indecisive, sexually inadequate, reasonably hard working, "mother's boys" with a tendency to drink excessively.

They also describe the overall structure of the couples' relationship. They believe that the essential ingredient to beating is the need both husband and wife feel for periodic reversal of roles: "She to be punished for her castrating activity; he to re-establish his masculine identity" (1964, p. 111).

Prescott and Letko (1977) raise the question of the relativity of social perception. They reframe Snell et al.'s characterization of the couple's dynamics by proposing an alternative conceptualization based on the many stories told by women victims of violent relationships. They write:

> What men describe as aggressiveness in females, women see as asserting their personal integrity; what men automatically see as masculinity in females, women sense as their own competence; what some men may see as frigidity, appears to women to be a natural lack of sexual responsiveness to their violent husbands; and what men see as masochism, women report as the sense of being trapped inside their marriages. (p. 73)

Contrary to Snell et al.'s speculation, Star's (1978) empirical findings also challenge the masochism theory, pointing to passivity, rather than the need for maltreatment, as the more appropriate rationale underlying the endurance of physical abuse. As other passive people, battered women in this study were reported to take little action on their own behalf. They are not initiators; they are the reactors to events. They believe that they are unable to affect change in their environment and that any action will only make a bad situation worse. More specifically, it was shown that battered women repressed anger,

were timid, were emotionally reserved, rigid, distrustful, easily upset, had low ego strength, and had low coping abilities. Also, they tend to be apprehensive, tense, frustrated, anxious, guilt prone, depressed and lonely. These women, however, showed no signs of being submissive people; instead, they scored within the normal range of the submissive-assertive continuum. They also maintained a balance between imaginative and practical concerns and were dependent upon their own resourcefulness.

These results were derived from comparing 46 physically abused and 11 not physically abused women who were staying at Haven House, a shelter in the Los Angeles area. Subjects were asked to fill out a background information form, the Buss-Durkee Hostility-Guilt Inventory, and the Cattell 16 Personality Factors (16PF). Star (1978) pointed to a sampling bias favoring lower socioeconomic level women. Also due to the special intake procedure of the shelter, the subjects were in various stages of crisis when they arrived at Haven House. This is considered to be an additional limitation of the study.

Faulk (1974) interviewed 23 men during the period of remand in custody awaiting trial on charges of seriously assaulting their wives. Sixteen were found to have serious psychiatric disorders, e.g., depression, dementia, delusional jealousy, post head injury syndrome, anxiety state, and personality disorder. The author also found the following five types of dynamics that describe the relationship of the offender to the victim:

1. Dependent passive husband
2. Dependent and suspicious husband

3. Violent and bullying husband

4. Dominating husband

5. Stable and affectionate husband (here the violence occurred during a depressive episode)

Lion's (1977) major argument is that wife beating is an outcome of two sets of dynamics which should be considered in the diagnostic process. He stated that the husband's dynamics are as relevant as those of the wife. However, he asserted that the victim plays a crucial role in this phenomenon. Overall, he believes that it involves the ambivalencies and pathologies of both partners. He characterizes the relationship as one of a complex, interlocking, hostile dependence which forms the basis for interlocking hatreds and animosities between two adult partners.

Shainess's (1977) psychiatric perspective on wife abuse is similar to the previous reviews with some modifications and/or additions of terms. She describes the "personality problems" of the husbands and their wives. Husbands are characterized as passive-aggressive, obsessive-compulsive, paranoid, sadistic, jealous, infantile, unable to tolerate frustration, and with low impulse control. Addiction to drugs and/or alcohol adds to the probability of assault. The battered wife is described as submissive and masochistic. According to Shainess, masochism does not imply enjoyment of suffering: "the women, because of low self esteem, fail to view their role as underdog and therefore do not take the necessary steps to free themselves from this kind of relationship" (1977, p. 117). Another characteristic that may elicit assaultive behavior of the husband is the healthy assertive behavior of the wife.

Recently, research reports from psychological schools are much less pejorative and blaming of the female victims. Hilberman and Munson (1977-78) observed the frequency of physical abuse among their women clients who had been patients of the clinic for an extended period of time. These women were treated for a variety of symptoms including depression, anxiety, somatic concerns, insomnia, and physical symptoms. Although battering was never mentioned as a presenting complaint, the authors discovered that, in a 12-month period, half the 60 women referred by the medical staff of a rural health clinic for psychiatric evaluation were found to be victims of marital violence. The researchers gradually became aware of physical abuse as the central causative factor in symptom formation.

Follingstad (1980) suggests a reconceptualization of the battered women issues. She postuates that the personality profile of abused women needs to be reviewed as a result of living in an abusive situation rather than as the antecedent that provokes abuse from the spouse. She postulates that the personality structure of the abused wife characterized by passivity, dependency, helplessness, and passive-aggressive expressions of anger is seen as an adjustment to the abusive situation rather than a provoking antecedent of abuse from the frustrated male. She also indicates that the personality traits exhibited by abused women closely parallel symptoms of learned helplessness, a concept that can be used to explain the perception of no alternatives, an inability to effect change, and passivity.

The empirical findings of her case study lend support to her theoretical argument. She found vast change in personality test data

pre- and post-therapy. The significant post-therapy decreases in MMPI personality scales as well as mood scales indicated vast personality changes in the battered woman client as a result of her successful attempts to change her environment.

Walker (1978) supports Follingstad's argument. Contrary to traditional psychotherapists, she is aware of the distinction between preexisting psychopathology and pathology that is induced by the battering. She writes:

> Battered women have related stories of being treated as though they engaged in "crazy" behavior. Many have been institutionalized involuntarily. In some cases, they were given so many shock treatments that their memories were impaired permanently. These women were diagnosed as paranoid, evidenced by their suspiciousness and lack of trust of people they feared might say the wrong thing to their batterers. . . . Many battered women's coping techniques, learned to protect themselves from further harm, have been viewed as evidence of severe intrapsychic personality disorders. My pilot research project has yielded data indicating that battered women suffer from situationally imposed emotional problems due to their victimization. They do not choose to be battered because of some personality deficit, but develop behavioral disturbances because of the battering. (Walker, 1978, p. 168)

Prescott and Letko (1977) noted some of the psychological effects of physical violence on battered women. Their study showed that 82% of the 40 battered women studied reported being fearful on the most recent occasions of physical violence. Ninety percent of the respondents reported anger resulting from the most recent occasion. Nearly three-fourths of the women reported being depressed, 68% reported feeling trapped, and 55% reported feelings of helplessness. Many women in this study reported a variety of other emotions and cognitions as a result of marital violence. Feelings of humiliation, guilt, inadequacy, unworthiness, and unattractiveness were identified by the respondents. Also, three-fourths indicated that the violence had produced a range of

negative effects, including a general distrust of men and fear of remarriage.

The psychological effects of battering were also pointed out by Hofeller (1982). It was indicated that 75% of the women reported that they felt embarassed because they were beaten, 66% said that they felt ashamed about the violence, 32% of the women suffered from psychosomatic illness during the marriage or the relationship, 78% reported that they had become severely depressed at some time, and 18% of the women attempted suicide at least once.

Walker-Hooper (1982) describes the state of emotional upset of battered women in the emergency department. She says:

> The victim is experiencing a crisis. She often has little energy and is physically and psychologically drained. Many feel helpless and worthless. Many have long ago accepted the blame for the violence; they are trapped and they feel responsible. The woman is usually very anxious. She often judges herself harshly and looks for signs for medical personnel that verify her feelings of inadequacy, shame, guilt, and embarrassment. . . . The battered woman is shocked, dismayed, and disconcerted. She is feeling used and betrayed. (p. 130)

Some writers noted that the main thrust of traditional psychological research on battered women can be described as taking the approach of "blaming the victim" (Fooner, 1966; Prescott & Letko, 1977; Symonds, 1975; Warner and Braen, 1982). The main premise of this approach is that the victim has, in one way or the other, contributed to her own suffering and victimization. The proponents of this approach believe that the victim has "stimulated" or "precipitated" the crime through propinquity, temptation, opportunity, and self-destructiveness.

In the psychological literature, causes of marital violence were attributed to personal or intrapsychic processes of the victims, rather

than looking at the phenomenon from a broader social and historical base. These studies did little to invalidate prevailing stereotypes concerning marital violence. Instead of maintaining scientific skepticism regarding common myths, mental health professionals seemed to contribute to perpetuating the status quo of traditional attitudes and perceptions of the victims of violence.

The question now arises as to why the victim is blamed for her mishap instead of being sympathized with. Recent findings in the field of victimology have revealed that there is universal human tendency to blame the victim when first hearing of a crime (Symond, 1979). Apparently, this reaction of rejecting the victim is expressed by accusing inquiry or hostile remarks. The following are comments and questions that are frequently addressed when wife abuse is discussed (Dobash & Dobash, 1979; Pagelow, 1981):

1. They must have deserved it.
2. They obviously like it.
3. They must need it.
4. They are masochists.
5. They are weak.
6. But what did she do to provoke him?
7. Why did she stay?
8. But they never press charges?
9. How can she put up with that?
10. What does she get out of the relationship?
11. There is not a problem. It only happens to the poor, and it is accepted by them as part of their way of life.

12. If I were married to her, I would beat her, too.

13. She must be sick and in turn making him sick.

14. She must enjoy the abuse; otherwise, she would take the children and leave.

15. The violent couple is attracted to each other because of mutual needs. A particular type of woman searches for a particular type of man (and vice versa), and the result is battering.

Symonds (1975), in his paper, focused on the neglected and ignored aspects of the victims' involvement with a violent crime. In contrast to society's accusing reaction, he stresses the innocent or accidental involvement of a victim with a perpetrator. He states:

> Early in my explorations on the subject of victims of violent crimes I became aware that society has strange attitudes toward victims. There seems to be a marked reluctance and resistance to accept the innocence or accidental nature of victim behavior. Such reluctance is shown by community responses, police behavior, family reactions, and surprisingly, by the victims themselves. Reluctance or resistance to accept or believe in the total innocence of the victims of violent crimes is shown by the early responses to victims after the initial shock response of the nonvictim listener wears off. "Didn't you know this neighborhood is dangerous to walk in after dark?" "Did you have your door locked?" "Weren't you suspicious of that man in the elevator?" "Why didn't you scream?" "Did you look before you opened the door?" In general, the theme follows a course of aggressive questioning along the line of "Didn't you know?" "Couldn't you tell?" "Why, why, why did it happen?" All these questions imply that the victims could have prevented or avoided their injuries. . . . People sometimes respond angrily to rape victims and say: "If she was stupid enough to go out in a neighborhood like that, she deserves it."
>
> This general early response to victims stems from a basic need for all individuals to find a rational explanation for violent, particularly brutal, crimes. Exposure to senseless, irrational, brutal behavior makes one feel vulnerable and helpless. It makes one feel that it can happen at any time, in any place, and to anyone. It is a relief to believe that the victim has done something or neglected something that plausibly contributed to the crime. It makes the other person feel less helpless and less vulnerable.

> The community has other attitudes that block sympathetic responses to the victim's plight. One is the primitive fear of contamination by the unlucky victim. The result of this primitive response of fear is to isolate or exclude the victim. . . . The victim of rape experiences isolation and exclusion through notoriety. There are whispering campaigns and a doubt as to the innocence of the victim. If she is young and single, she is subjected to annoying behavior by men in the community without the usual protective interference of other individuals. (pp. 19-21)

This tendency of viewing the victim as responsible for his/her own misfortune can also be explained within the framework of both cognitive dissonance and attribution theories. According to these theories, the awareness of a senseless act of violence is an upsetting experience which typically throws people off balance, shakes their view of the world as an orderly, just, and predictable place, and provokes their own feelings of vulnerability.

Labeling the victim as masochist, sadist, insane, alcoholic, depraved, sick, seductive, provocative, poor, etc., is one way of conflict resolution. People try to make sense of the many senseless acts of violence. Their primary goal is to reduce their own tension and distress and to achieve a sense of relief. Attributing the cause of violence to the victim may convince people that such violence would not happen to them because they would behave differently under similar circumstances. It allows the listener to maintain an attitude of equity in the world and reinforces the belief that, in a just world, people get what they deserve (Warner, 1982).

Women and Depression

There is a large body of literature which consistently demonstrates the influence of sex on depression. The fact that more women are depressed than men is well documented (Benfari et al., 1972; Goldman

& Ravid, 1980; Markush & Favero, 1974; Radloff, 1975; Weissman & Klerman, 1977).

Weissman and Klerman (1977) critically reviewed the evidence for differing rates of depression between the sexes in the United States and many other different countries during the last 40 years, between 1936 and 1973. The evidence was derived from four sources of information: (1) clinical observations of patients coming for treatment, (2) surveys of persons not under treatment, (3) studies of suicide and suicide attempts, (4) studies of grief and bereavement. The authors concluded that the evidence from international comparisons of diagnosed and treated depressed patients and from community surveys that include both treated and untreated persons is amazingly consistent. With few exceptions, depression is more frequent among women than among men in all countries and all times. When the authors decided to use rates of suicide attempts as an indirect index of depression, they noticed that a consistent trend emerged. All countries report an increase in suicide attempts over the last decade. The female-male ratio in suicide attempts is about 2:1 in Australia, Great Britain, the United States, and Israel. In India, the sex ratios are reversed, and in Poland the sex ratios are nearly equal for suicide attempts. No differences between the sexes were found regarding the frequency of depressive symptoms following bereavements.

Eaton and Kessler's (1981) findings show the nature of association of sex and depression in a nationwide representative sample of the U.S. adult population. Their data were collected during the National Center for Health Statistics' first Health and Nutrition Examination survey in 1971-1975. They found that 20% of the females and 10% of the

males were above the depression cutting score. This pattern of association was reported to be unaffected by controlling other demographic factors.

Comstock and Helsing (1976) obtained depression scores from 3,845 randomly selected adult residents of Kansas City and Washington County. In both populations, more females than males had high depression symptom scores. Adjustment for the effects of other socioeconomic variables reduced the sex differences, but did not remove them. No significant differences were found between black females and males.

The fact that the data of these two studies were derived from a national sample adds weight to the conclusion that the relationship between sex and depression is stable in a variety of populations. Another advantage of survey data is that they obtain information from people who are not under treatment. This is important due to the fact that the majority of people suffering from psychiatric disorders do not seek treatment (Weissman & Myers, 1978). However, it is important to note that similar and consistent results are also obtained from more localized samples.

Marital Status and Depression

The relationship between marriage and depression has been systematically studied showing significant correlation between depression and married women. Married women tend to have a higher incidence of depression than married men (Coleman, 1975; Radloff, 1975). In an examination of 17 community and utilization studies, Gove (1972) finds that in all of the studies married women have higher rates of mental illness than married men; in 11 out of 15 studies, single men have

higher rates than single women. Goldman and Ravid (1980) also reviewed 22 community surveys that focus on sex differences in mental illness. Their most consistent finding is that single men are more "maladjusted, mentally impaired, or depressed than single women" (p. 47). They reported that in no study are single women shown as more prone to mental illness than single men. Gove (1972) theorizes that being married "protects" men against mental illness. However, marriage promotes mental illness in women.

According to Klerman and Weissman (1980), the findings that married women suffer more mental distress than married men or single women and that unmarried women have lower rates of mental illness than unmarried men support the notion that these differences are not entirely due to biological factors intrinsic to being female, but are partly caused by the conflicts generated by the traditional female role.

Clinical depression was found to be related to poor interpersonal relations within the marriage. This claim was supported by studies of depressed women during psychiatric treatment. Paykel et al. (1969) find that marital discord was the most common event reported by depressed patients as having occurred in the previous six months. Weissman and Paykel (1974) find that acutely depressed women as compared to matched normal groups reported considerably more problems in marital intimacy, especially in their ability to communicate with their spouses. Moreover, these marital problems often were enduring and did not completely subside with symptomatic remission of the acute depression.

Radloff (1975) finds divorced or separated women more depressed than men of this category. Gurin et al. (1960) also noted that divorced

or separated women are more poorly adjusted than men. Morse and Furst (1982) indicated that divorce is a specially traumatic event that negatively affects women and men. However, they report several studies that support the claim that the incidence of depression is much higher in separated or divorced women than it is in separated or divorced men.

The question of causation naturally arises: Why are women more prone to depression than men? Morse and Furst (1982) present eight possible reasons for the higher female incidence of depression. These causes are as follows:

> 1. Women are not taught to show anger; they are brought up to control their emotions which leads them to internalize their feelings.
> 2. Girls have greater dependency upon their mothers than do boys; they are provided with fewer opportunities for independence and individualization.
> 3. In adult life, women may become dependent upon their husbands or lovers for support and emotional attachment; when a loss of the person she is dependent upon occurs (as with divorce or death), the woman may then go into a state of depression.
> 4. Women get treatment for their symptoms of both physical and mental disease more than men do; hence, more female cases are reported.
> 5. The menial housewife role tends to foment depression.
> 6. Even when women work, their role is often subservient to men or dependent upon them.
> 7. Married women who are working usually have the menial housework to do and may feel guilty about leaving the children at home.
> 8. Most of the reported studies on depression have been done by men; there may be male bias in labeling more women than men as being depressed. (p. 63)

Theories of Preponderance of Women among Depressives

The Social Status Hypothesis

One of the explanations provided by Klerman and Weissman (1980) is termed the social status hypothesis. It emphasizes the low social

status and the legal and economic discrimination against women. They argue that many women find their life situations depressing because the real social discriminations make it difficult for them to achieve mastery by direct action and self-assertion, which only further contributes to their psychological distress. Applied to depression, it is suggested that these inequities lead to legal and economic helplessness, dependency on others, chronically low self-esteem, low aspirations, and, ultimately, clinical depression (Weissman & Klerman, 1977).

To test this hypothesis that high rates of depression are related to the disadvantages of the woman's social status, particular attention has been given to the impact of marital status on mental health. Weissman and Klerman (1982) argue that if the social status hypothesis is correct, marriage should be of greater disadvantage to the women than to the men, since married women are likely to embody the traditional stereotyped role and should therefore have higher rates of depression.

Gove and Tudor (1973), in particular, have focused their research on examining rates of mental illness among married women as compared with single women and married men. Their main finding was that the higher overall rates of many mental illnesses for females are largely accounted for by higher rates for married women. They found that, in each marital status category, single, divorced, and widowed women have lower rates of mental illness than men. They attributed the male-female differences in the rates of mental illness to traditional adult sex roles.

They believe that the ungratifying, restrictive, often demeaning role that married women play in modern western societies is a source of emotional problems. They argue that, generally speaking, the married woman's major societal role--that of housewife--entails frustrating, unstructured, and hardly prestigious chores such as raising children and housekeeping. The typical married working woman is discriminated against in the job market, is more committed to supplementing the family income than to furthering a career, and must bear the additional onus of doing the housework. To put it differently, their findings and conclusions support the view that elements of the traditional, stereotypical female role may contribute to depression.

Biological Hypothesis

Evidence for female physiological susceptibility to depression is derived from the possibility of a genetic transmission and female endocrine physiological processes (Weissman, 1980).

Genetic factors

There are four sources of evidence for the genetic hypothesis: family-aggregation studies comparing illness rates within and between generations of a particular family; studies of twins comparing illness rates in monozygotic and dizygotic twins; cross-rearing studies; linkage studies, in which known genetic markers are used to follow other traits through several generations or in siblings.

Weissman and Klerman (1982) concluded that the available evidence summarized by several investigators reveals an increased morbid risk of depression in the first-degree relatives of diagnosed

depressives as compared to the general population and a higher rate of depression in identical than in fraternal twins. Overall, there is reasonable evidence of a genetic factor operating in the more severe types of depressive illness. However, the evidence from genetic studies is still insufficient to draw firm conclusions about the nature of transmission or to explain the sex differences.

Endocrine reasons

Evidence for the possible relationship between female sex hormones and depression is based on the observations that clinical depression tends to occur in association with events in the reproductive cycle, such as menstruation, use of contraceptive drugs, the postpartum period, and menopause. Weissman and Klerman's (1982) review of this evidence leads them to believe that the pattern of the relationship of endocrine to clinical states of depression is inconsistent. They concluded that there is good evidence that premenstrual tension and use of oral contraceptives have the effect of increasing rates of depression, but the effect is probably of small magnitude. They reported that there is excellent evidence that the postpartum period does induce an increase in depression. Contrary to widely held views, there is good evidence that menopause has no stimulatory effect on rates of depression (Weissman, 1979).

The Artifact Hypothesis about the Sex Difference

An opposing explanation to the previously mentioned interpretations of sex differences in the etiology of depression is offered by Phillips and Segal (1969). They speculate that the disproportionately

greater rate of mental illness among women is due not to "real sex differences in the frequency of disturbance but rather to man's greater reluctance to admit certain unpleasurable feelings and sensations" (p. 69). It is suggested that "women may be more likely than men to report certain acts, behaviors, and feelings that lead to their being categorized as mentally ill . . . because is it more culturally appropriate and acceptable for women to be more expressive about their difficulties" (p. 59).

Klerman and Weissman (1980), Weissman (1980), and Weissman and Klerman (1977, 1982) also raised the question of whether the sex differences findings are "real" or an "artifact." The artifact hypothesis proposes that depressions are considerably more common in women than in men as a function of women's perception, acknowledgment, willingness to express, report, and to seek help for stress and symptoms differently from men. Also included under the artifact hypothesis is the observation that alcohol use and abuse are considerably more common in men. It was hypothesized that depressed men mitigate their symptoms of depression by drinking.

As a result of their intensive efforts to deal with the artifact hypothesis and after reviewing research evidence related to it, Weissman and Klerman (1982) arrived at the conclusion that the sex differences are not an artifact; they are real. Women report more symptoms of depression in western industrialized societies simply because they actually and objectively experience more symptoms.

It is well documented in the literature that depression produces far-reaching and lingering impairments. It can negatively affect many important facts of the depressives' lives.

Weissman and Paykel (1974) conducted a comprehensive study on the effect of depression on social, family, and community adjustment. Over the course of 20 months, they followed the social adjustment of 40 depressed women and compared them with 40 women of similar social class, place of residence, race, religion, and marital status who had no major physical or emotional problems and had never received psychiatric treatment. Their findings indicated that depressed women are considerably more impaired in their daily lives and interpersonal relationships than the normal group. Their social impairment reaches into all roles as wife, mother, worker, and member of the community. The impairments are most marked in work and in the intimate relationships of marriage and parenthood. They are less marked in the less emotionally charged and distant relationships with friends, acquaintances, and the extended family. Interestingly, work performance was also considerably impaired, but less so for women who were employed outside the home.

Traditional psychoanalytic theories suggest that there are pre-existing character traits predisposing to depression and liable to persist after symptomatic recovery. Abraham (1968) described the depression-prone person as dependent, sensitive to loss of love, and having basic defects in self-esteem. Weissman and Paykel (1974) presented the most common themes found in the psychoanalytic literature which describe the personality traits of the depression-prone individual. These traits include sensitivity to situations of loss,

obsessionality and conscientiousness, dependency and submissiveness, difficulties with hostility, defective communication in interpersonal relationships, and vulnerability to blows to self-esteem. However, results of empirical studies fail to confirm that depression proneness is related to specific traits or any consistently uniform pattern of the depressed personality other than perhaps a general tendency to neuroticism, which might be reflected in a tendency to maladjustment without any specific pattern (Weissman & Paykel, 1974).

This chapter summarizes the current state of knowledge on the subject of wife abuse and its relation to particular emotional states of depression and anxiety. A selected sample of numerous theoretical perspectives derived from the fields of psychology, sociology, and feminism is presented. This theoretical diversity illustrates the multidimensional nature of the causation of spouse abuse. It also reflects the biases and training backgrounds of their creators. This is not to say that the causes of wife abuse solely rest in the eye of the beholder, but rather they reflect the interplay between the subjective and objective--the inner and outer nature of the problem and those who deal with it.

In addition, findings of empirical research are cited. It is observed that research trends in this area could be classified into two main streams: First are the studies with special focus on the extent and commonality of wife abuse. The outcomes of these studies lead to a consistent conclusion in spite of the differences in the sources and methodologies of the studies. They all seem to agree that, although the phenomenon is underreported, it still occurs in a strikingly large

number of American families. Second are the studies which stress the demographic and psychological characteristics of the victims and their offenders. Here, there is more room for conflicting evidence. While a group of researchers found that wife abuse occurs across all ages, races, ethnic groups, socioeconomic levels, and educational levels, others present findings which document the prevalence of wife abuse in black and low socioeconomic status families. Also, the research findings regarding the personality profile of the battered woman are ambiguous. Two contradictory points of view are presented. One advocates the presence of particular personality traits which characterize victims of abuse. In contrast, the other viewpoint does not suggest any specific traits that distinguish those who are battered from those who are not. The proponents of this model believe that there is no such profile, since any woman can be the victim of abuse at one point or another.

In light of the literature review, one may safely conclude that the first stage of recognizing and accepting the depth and breadth of the problem is over. Wife abuse has received more than adequate media exposure and public attention throughout the last decade. Now the time has come to evaluate the effectiveness of programs designed to treat the victims of abuse and their families and to substantiate empirically the observations of professionals as to the intensity of distress and the emotionally disabling effects of the battering experience. It should be added that, until the present time, evaluative research of changes over time has rarely been done simply because it is energy and time consuming and requires pre- and posttesting. Consequently, the purpose of this study is to fill some of the gaps in the literature by focusing on the following neglected areas:

1. Objective assessment of the adverse consequences for personality functioning that battering may bring. Special attention would be paid to the devastating effects of depression and anxiety.

2. Examination of the impact of treatment in determining whether the symptoms are a result of living in violence or the cause of it. The results of this study may shed some light on whether these symptoms are transient and will be drastically reduced as a result of being at the shelter or indicative of long-standing personality traits of the victims.

3. To identify the victims' motives and coping powers which played a significant role in the process of making the decision to leave their destructive relationships.

4. Obtaining a subjective evaluation of the meaning of the victims' experience at the shelter.

The inherent premise of this study is that understanding the dynamics and consequences of abuse can be translated to developing special skills and creating appropriate services that will prevent the occurrence of violence and facilitate the process of healing of those who are subjected to it.

CHAPTER III
METHOD

Subjects

The total number of respondents is 70 women who are divided into two groups. The experimental group is composed of 40 self-identified battered women who were current residents of battered women shelters. The comparison group includes 30 non-battered women selected from a women's health clinic. All respondents, both battered and non-battered women, are volunteers who consented to participate in this study.

The health clinic serves a wide range of women who come from different income and educational backgrounds. The advantage of such a setting is that it increases the heterogeneity of the population to be studied.

The battered women group is drawn from two shelters which are located in different income-bracket neighborhoods. The two shelters provide services to women who reside in a large metropolitan area on the east coast of the United States. One shelter is located in a suburb, the other is in the city. The names of the shelters are not identified here because the board of directors of one of the shelters has requested that this information be kept anonymous.

Both shelters seem to have a similar philosophy and policy toward helping victims of abuse. Both are committed to the self-help model and peer support as a method to achieve independence, self-worth, and control. Personnel at both shelters believe in discouraging program

dependency. Women are expected to take care of themselves, rely on their own resources, and assume personal responsibility for their own choices.

Services provided by the two shelters are also similar. Staff and volunteers provide assistance and information in the areas of legal advocacy, psychological support, medical aid, vocational counseling, housing, public assistance, and child care. Crisis intervention, secure shelter, and food are also basic ingredients of the two programs.

However, the two programs differ in terms of their capacity and the length of stay they allow for their residents. The first shelter has a capacity of about 21 women with children. The exact number of women residing at the shelter over a period of time varies according to the number of children each woman has. Each child is counted as one person. Hence, the higher the number of children, the lower the number of women residents.

The length of stay at this shelter ranges from 1 day to 6 weeks. Although residents are not encouraged to stay beyond the 6-week limit, a maximum of one 2-week extension is granted on a case-by-case basis, depending on circumstances and efforts displayed. If the staff feels the resident is not taking steps to help herself or if the resident violates shelter rules, she may be asked to leave.

The other shelter provides space for 10 women and their children with an average of 7-10 residents. The length of stay ranges from 1 day to 3 weeks. Extensions are also negotiable.

Pagelow (1981) pointed out the advantages of obtaining a sample of battered women through shelters. Some of her views are adopted to explain the position taken in this investigation. First, sampling

through shelters allows access to many women who identify themselves as battered. Therefore, the researcher is relieved from the responsibility of making a value judgment as to who is or is not a battered woman. In addition, women callers go through a screening interview by a staff person in order to determine their eligibility for residency. Only those who fit the criteria are admitted to the shelter. Second, the warm, safe, supportive, and non-judgmental atmosphere of most shelters, which encourages women to share their experiences with each other, is apt to set the stage for openness, honesty, and self-disclosure. Third, sampling from two different shelters may broaden the socioeconomic and racial distribution of the sample. This is in contrast to the tendency of studies in this area to overrepresent women from the lower classes. Finally, data from shelters are useful for policy makers and government funding agencies for decision-making purposes.

However, there are numerous disadvantages in conducting this study. Here are some of the difficulties that were encountered during the process of data collection:

1. Limited access to shelters for battered women. In general, the number of shelters for battered women is very minimal. For example, in a large city with a population of over 1 million, there is only one shelter available. However, of the 12 shelters contacted within a 100-mile radius, only 2 responded positively. One of the two shelters granted permission to interview women for a period of 2 months only. This was due to making the shelter available to another researcher who was also given permission to conduct her study there. The shelter approval of research projects is consistent with its policy to encourage

researchers to conduct their studies in the area of wife abuse. However, this policy does not reflect the typical behavior of the vast majority of shelters which were contacted. Some of these shelters were contacted for the first time for research purposes, and they had to decide upon formulating a policy to handle such requests. Others were doing their own research and did not want to burden or overutilize their residents for additional private or organizational research. Still other groups of shelters stated that they felt rather uncommitted to doing any research. They were more interested, concerned, and directed toward service delivery. Those who believed in the importance of research, but were not actively engaged in it, expected that they will, in the future, generate their own statistics and conduct their own research in the field of domestic violence. Overall two dominant attitudes were portrayed by the shelters' directors: overprotection of residents and monopoly of research in shelter settings.

Directors of women's health clinics responded similarly. Although 10 of them were contacted, only one agreed to participate. The rationale for their negative reaction was that their clients might feel obliged to volunteer since the clinics provided free services.

2. A small number of women can reside at the shelter due to its limited capacity and to the relatively high number of children who accompany their mothers. The average number of women ranged from 7 to 10, thus resulting in an extremely slow turnover of residents (the duration of stay had been from 3 to 8 weeks).

3. Many women leave the shelter prior to the time lapse for post-test follow-up. For example, five women were expelled from the shelter immediately after violating the "confidentiality rule" (i.e., each woman was told that the address of the shelter is secret and that she should not reveal the name, address, or vicinity of the shelter to anyone including family, friends, lovers, husbands, boyfriends, co-workers, lawyers, etc. They were also informed that visitors are not allowed in or near the shelter). Also, there is no post-test information available on women who prematurely terminated and went back to either their husbands or to their families of origin. Finally, one woman did not show up at a follow-up session in spite of repeated scheduling hours.

4. Several women refused to participate in the study. Some of them indicated that they did not want to talk about their experience because they "want to forget about it" or "there is no use in talking about it" or "talking is not going to help" or "it's their own private business" or "they were afraid that the interview will elicit painful memories." Others expressed their interest in participating, yet they were "no shows" when the interviews were scheduled.

5. Due to all of these limitations, it was impossible to have a random sample. Therefore, this is a specific, purposive, self-selected sample of battered women. This lack of randomness in the sample will, of course, restrict generalizations of the findings.

6. The data are retrospective. They are based on women's recall of events that occurred within the length of the relationship with abusers. However, Pagelow (1981) pointed out that these

retrospective data appear to be sufficiently reliable and the best available to researchers due to the privacy of the home and the impossibility of direct observations of the violent acts. Also, due to the traumatic nature of the violent behavior, battered women tend to vividly remember the details of the violent attacks. For example, a 36-year-old white married female, who came to the shelter with her 9-year-old daughter, stated during the interview that she still remembers very clearly the first incident of battering, although it happened 10 years ago. These limitations probably contributed to obtaining the composition shown in Table 1.

TABLE 1
AGENCY BY TIME OF TEST ADMINISTRATION

	Pre	Post	Missing Cases
Shelters	40	25	15
Health clinic	30	18	12

Procedure

Several shelters in a large metropolitan area were contacted. Permission to gather information from their residents was requested. Two shelters agreed to participate. Women residents in each shelter were contacted individually by the researcher and were informed about the purpose and procedure of the study. Although women were encouraged to participate, it was emphasized that participation was voluntary and refusal would in no way affect their stay or treatment at the shelter.

Women's right to confidentiality was also stressed. Therefore, all respondents were volunteers who consented to participate in the study.

The same procedure was used to recruit women for the control group. Several women's health clinics were contacted, and the data were derived from the one clinic which consented to participate. Data were collected from the beginning of December 1983 to the end of July 1984.

Information presented here is based on objective tests, questionnaires, and interviews. Data from battered and non-battered women were derived through administering the following inventories: (1) Beck Depression Inventory, (2) State-Trait Anxiety Inventory, and (3) background information questionnaires. Additionally, the battered women group only was given an evaluation form of shelter experience.

Although the objective measures are self-administered, paper-and-pencil inventories, it was decided to read each statement in each category of the BDI and then ask the woman to select the statement that seemed to fit her best at present. The woman also had a copy of the inventory so that she could read each statement to herself as the interviewer read it aloud. The interviewer circled the number beside the statement picked by the respondent. The same approach was used in administering the two forms of the anxiety inventory.

The investigator also conducted a personal interview with each of the women in the experimental group regarding their battering experience. The form of the interview was semistructured. This procedure gives a better sense of the overall functioning of the battered women. It helps to elicit more information from the respondents, and it is more personal and humane than just distributing and collecting the research

material without having any direct contact with the women. Additionally, reading aloud the statements solved the problems of language barriers that some of the women may have. This procedure prevented the exclusion of women unskilled in reading and writing English or women for whom English is a second language.

The first meeting with the battered women took place on the third or fourth day of their stay at the shelter. The reason for this arrangement is to insure that the women have settled in and partially recovered from the initial state of psychological crisis.

The initial phase of assessment provides information regarding the emotional states of battered women when they first come to the shelter. During the first interview, the Background Information Questionnaire, the BDI, and the STAI were completed. The length of each interview ranged from 1 to 2 hours. After 3 weeks of stay at the shelter, the depression and anxiety scales were administered again. Also, each woman was engaged in a semistructured interview that specifically addressed issues relating to the subjective meaning of her experience at the shelter.

The purpose of the second assessment was to examine the impact of treatment on changing the levels of internal distress experienced by battered women and to get feedback from the victims themselves about their own personal needs when they come into the shelter.

The same process of administering the research material was followed with the control group. However, it was briefer, since the Background Information Questionnaire for this group was shorter. Also, in the second assessment stage they only had to complete the depression and

the anxiety scales. Another procedure difference between the two groups was the timing of the initial administration of the questionnaires. The control group was given the research material during the first visit to the clinic (not 3 days later as was done for the experimental group).

The diagram in Figure 1 illustrates the experimental design used in this study.

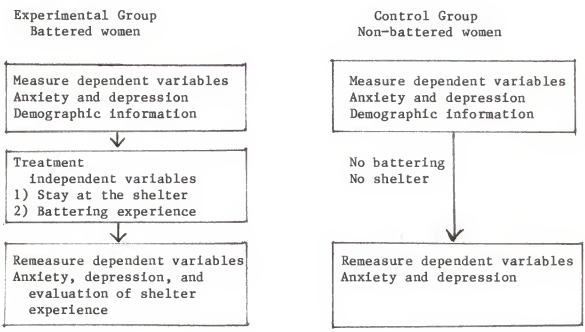

Fig. 1. Experimental design

Instruments

The following measures were employed to assess the psychological functioning and the social conditions of battered and non-battered women. The selection of scales was based on such criteria as frequency of utility, validity, and reliability. Those inventories with the highest utility, reliability, and validity were included. A detailed description of the rationale for choosing such inventories as well as

the limitations and virtues of each instrument will be addressed shortly.

Beck Depression Inventory

Utility

The BDI has been used extensively used in studies of depression. Beck and Beck (1972) reported that this instrument has been used as a criterion measure in well over 100 published studies. Ten years later, Reynolds and Gould (1981) confirmed the Becks' observation. They noted that the BDI has been viewed as one of the better self-report measures of general depression and has become a widely used measure in clinical research. However, the popularity of a psychometric test is not a sufficient index of its effectiveness. For example, the Depression Scale (D-Scale) of the Minnesota Multiphasic Personality Inventory (MMPI) has been used extensively in clinical and research circles. Yet, one of its main disadvantages is that the factor analytic studies showed that the D-Scale contains a number of heterogeneous factors, only one of which is consistent with the clinical definition of depression. Therefore attributing unitary significance to the D-Scale is questionable. Also, Beck and Beck (1972) assert that the BDI is unlike the MMPI because it is not sensitive to the social desirability and the acquiescence response sets.

Rationale

The BDI was selected to assess the changes in the depth of depression as a result of treatment. There are many assets which characterize this inventory. First, the BDI was carefully constructed as a

reaction to encompass the difficulties posed by the use of clinical judgments and the inadequate self-rating scales for the measurement of depression. As mentioned earlier, the D-Scale of the MMPI has various disadvantages. Hamilton's (1960) rating scale for depression requires administration by experienced diagnosticians. The adjective checklists for the measurement of depression tend to sample a very limited range of depression symptoms which focus primarily on depressed affect (Clyde, 1961; Zuckerman & Lubin, 1965). This is in contrast to the BDI, which is a more sensitive instrument to the assessment of the full range of the depressive syndrome. Unlike the checklists, the BDI includes items involving affective, physiological, cognitive, and motivational manifestations of depression. Second, the BDI provides a standardized, objective, and consistent measure that does not rely on the theoretical orientation of the interviewer. Third, it is far more economical than the psychiatric interview, since the inventory can be self-administered or can be administered by a minimally trained interviewer. In addition, the inventory provides a numerical score which can be compared with other quantitative data. Finally, the instrument is a more sensitive indicator of changes in the depth of depression than clinical judgments based on a psychiatric interview; therefore, it can objectively measure improvement resulting from treatment. One more point which favors the use of the BDI over other instruments and is of particular relevance to the present study is that, as compared to other psychometric instruments, the BDI was found to be highly effective in discriminating between depression and anxiety (Beck, 1972).

Despite all of these advantages, there were several problems inherent in the so-called objective instruments. Horn (1950) expressed his objection to objective instruments. He challenges the assumption that the items in an inventory convey the same or similar meaning to everyone who takes the test. He questions the efficacy of a self-rating inventory as an accurate self-evaluation. Beck (1967) also presents the special problems posed by using the inventory. First, he addresses the issue of accuracy with which patients can discriminate between alternative statements in each item. Second, Beck questions the effects of response sets on contaminating the objectivity of self-report instruments. Third, Beck challenges the validity of the assumption that the cumulative score over a large number of items on a personality scale reflects the intensity of the variable being measured. He also argues that fractionating a form of disturbed behavior into a number of separable units actually produces a distorted measure of this behavior which can be appropriately evaluated only by a holistic approach.

Beck's approach to cope with these problems was to use the clinical ratings of experienced diagnosticians as the initial criterion against which to judge the validity of the BDI. By doing so he hoped to maximize the advantages of both the psychometric and clinical approaches for the assessment of depression.

Description

The BDI is a paper-and-pencil, self-evaluative measure of depression. It contains 21 categories of symptoms and characteristic attitudes which are descriptive of the depressed patient. The form of the instrument was related to two observations: (1) with increasing

severity of depression, the number of symptoms increases, and there is a step-like progression in the frequency of depression symptoms from non-depressed, to mildly depressed, to moderately depressed, to severely depressed patients; (2) the more depressed a patient is, the more intense a particular symptom is likely to be (Beck, 1967).

Each item in the scale resembles a particular manifestation of depression and consists of four alternative responses assigned values from 0 to 3. These numerical scores indicate the degree of severity of depression. High scores indicate a deeper level of depression. The total score is obtained by adding the scores of each statement. In many categories, two alternative statements carry the same weight; these equivalent statements are labeled "a" and "b" (e.g., 2a, 2b) to indicate that they are at the same level. The range of possible scores extends from 0 to 63, with scores of 0-9 being categorized by Beck as not depressed, 10-15 as mildly depressed, 16-23 as moderately depressed, and 24-63 as severely depressed.

The instrument consists of the following symptom-attitude categories which were derived from clinical records and observations:

1. Mood
2. Pessimism
3. Sense of failure
4. Lack of satisfaction
5. Guilty feeling
6. Sense of punishment
7. Self-dislike
8. Self-accusations

9. Suicidal wishes
10. Crying spells
11. Irritability
12. Social withdrawal
13. Indecisiveness
14. Distortion of body image
15. Work inhibition
16. Sleep disturbance
17. Fatiguibility
18. Loss of appetite
19. Weight loss
20. Somatic preoccupation
21. Loss of libido

Reliability

Two methods of evaluating the internal consistency of the inventory were used:

1. Protocols of 200 consecutive cases were analyzed, and the scores for each of the 21 items were compared with the total score on the BDI for each patient. All categories showed a significant relationship to the total score for the inventory. A subsequent item analysis of 606 cases showed that each item had a significant positive correlation with the total BDI score (Beck, 1972).

2. Ninety-seven cases were selected for determining the split-half reliability of the BDI. The Pearson r between the odd and even categories was computed and yielded a reliability coefficient of .86; a Spearman-Brown correlation for attenuation raised the coefficient to

.93. Test-retest and inter-rater/reliability did not seem appropriate methods of assessing the stability and consistency of the BDI because of the possible influence of memory on the scores and the changing nature of depressive moods (Beck & Beamesderfer, 1974). Because of these considerations, two indirect methods of evaluating the stability of the inventory were used. The first was a variation of the test-retest method. The inventory was administered to a group of 38 patients by a technician at two different times with a mean interval of 4 weeks between the two tests. Each time, a clinical rating of depth of depression was made by a psychiatrist. Changes in BDI scores parallelled changes in the clinical ratings of the depth of depression.

An indirect measure of the inter-rater reliability was achieved by comparing the scores obtained by each of the three participating technicians with the clinical ratings. The mean scores obtained at each level of depression were identical among the interviewers when the BDI scores were plotted against the depth of depression; curves were notably similar, indicating a high level of agreement among those who administered the inventory (Beck & Beamesderfer, 1974).

Reynolds and Gould (1981) provided further information regarding the psychometric characteristics of the BDI. The BDI was administered to a group of 163 males and females who were involved in a methadone maintenance drug rehabilitation program. They found that the internal consistency (coefficient alpha) reliability was .85. This result is consistent with Beck and Beamesdserfer's (1974) findings.

Validity

Concurrent validity of the BDI was determined by how well the test scores correlated with other measures of depression. Concurrent validity of the BDI was demonstrated in a number of studies by comparing the test scores with clinicians' global ratings of depth of depression. The inventory was found to correlate .65 with the clinicians' ratings (Beck et al., 1961); in a drug study the correlation was .66 (Nussbaum & Michaux, 1963); in a British study the correlation was .616 (Metcalfe & Goldman, 1965). In a study of the BDI in general practice, Salkind (1969) found the correlation coefficient between the BDI and depth of depression ratings to be .73. Similar correlations were obtained in comparisons between the BDI scores and clinicians' ratings in Czechoslovakia, Finland, France, and Switzerland (Beck & Beamesderfer, 1974). Bumberry et al. (1978) investigated the utility of the BDI for survey use in a college population. They found a correlation of .77 between the BDI and the psychiatric rating. This finding indicates that the BDI is a valid instrument for use in a college population.

Concurrent validity has also been demonstrated through comparisons with other standardized measures of depression. Nussbaum and Michaux (1963) found initial and final correlations between the MMPI D-Scale and the BDI to be .75 and .69, respectively. Schwab et al. (1967) obtained a correlation coefficient of .75 between the BDI and Hamilton's Rating Scale for depression. Spitzer et al. (1967) computed the correlations between the Mental Status Schedule (MSS) and a number of other measures including the BDI. The feelings-concerns scale of the MSS correlated .58 with the BDI: the "depression-anxiety" scale

correlated .55 with the BDI. Bloom and Brady (1968) compared the depression scale of the Multiple Affect Adjective Check List (MAACL) to the BDI. They found a correlation of .66 between the BDI and the MAACL. Reynolds and Gould (1981) obtained significant correlations between the BDI and the Zung Self-Rating Depression Scale and University of California-Los Angeles Loneliness Scale (r = .67 and .42, respectively).

In a cross-cultural study of depressive symptoms, Zung (1969) found a correlation of .76 between the BDI and his Self-Rating Depression Scale (Zung, 1965) in England. The correlation was .72 in Germany. A group of researchers compared behavioral measures of depression to the BDI and Hamilton's scale. They found a correlation of .82 between the Beck and Hamilton scales and a correlation of .67 between the BDI and behavioral measures. Therefore, it was concluded that there is solid evidence to support the concurrent validity of the BDI (Beck & Beamesderfer, 1974).

Construct validity of the BDI is determined by testing the following hypotheses: (1) depressed patients are most likely to have a certain kind of dream characterized by "masochistic" content; (2) they are most likely to have a negative self-concept; (3) they identify with the "loser" on projective tests dealing with success and failure; (4) they have a history of deprivation that sensitized them to depression in a later life; (5) they respond to experimentally induced failure with a disproportionate drop in self-esteem and increased in hopelessness; (6) following a success experience, depressed patients will show a significant subjective and objective improvement; and (7) they show a high correlation between intensity of depression and suicidal intent

(Beck & Beamesderfer, 1974). Using the BDI as a criterion measure, these predictions were supported by several studies. Beck, Ward, Mendelson, Mock, and Erbaugh (1961) found a significant relationship between depression and "masochistic" dreams. Beck and Beamesderfer (1974) reported that depressives scored high on a self-concept test, with high scores indicating negative self-concept. Beck (1961) found that depressed patients identified with the "loser" when presented with a series of pictorial stimuli. Beck et al. (1963) obtained a significant relationship between childhood bereavement and adult depression. Loeb et al. (1964) demonstrated that depressed patients make excessively pessimistic predictions after inferior task performance. Loeb et al. (1971) also found that following successful completion of a manual task, depressed patients showed a significant improvement in optimism, self-evaluation, and performance.

Gottschalk et al. (1963) found a significant correlation (.47) between scores on a "hostility-inward" scale and the BDI, and a negative correlation between a "hostility-out" scale and the BDI. Mendels and Hawkins (1968) showed that depressed patients experience a sleep disturbance that reverts to normal when the depressive episode is terminated. Beck (1972) found that depressed patients are more pessimistic than are nondepressed patients, but that they return to normal after recovery.

Since all of the previously mentioned hypotheses were confirmed, the BDI is strongly supported for its construct validity.

The State-Trait Anxiety Inventory

Utility

The popularity of the STAI was documented in the 1978 Mental Measurements Yearbook. This book appears to be a valuable source to obtain frankly factual and critical information about the virtues and limitations of competing standardized tests. The STAI had been reported to generate 332 references in the eight Mental Measurements Yearbooks (Buros, 1978). It is important to note that the editor used somewhat restrictive criteria for listing a publication as a reference. For example, bibliographies prepared by others for their own tests had not been used.

In a critical in-depth review of the strengths and weaknesses of the STAI, Katkin (1978) also noted the popularity of this instrument. He writes: "Research with the STAI has been proliferating to the point where there is probably more published research on the STAI, and more ongoing research now on the STAI, than on any other commercially available anxiety inventory" (p. 1096). Dreger's (1978) evaluation of the popularity of the inventory is similar. He writes:

> The revised STAI is one of the best standardized of anxiety measures, if not the best . . . it appears that it is a popular test. For instruments of its type it appears to be deservedly popular, in that the reliabilities are nearly as high as one would expect for intelligence scales; it demonstrates expected differences among groups of persons; and its state form generates nonrandom factor structures when used over time. (p. 1095)

Rationale

The STAI was used in this study simply because it has been suggested by several reviewers as an excellent choice for clinical or research purposes. Of particular significance to this study is the

virtue of the stability of the A-Trait scale and the sensitivity of the A-State scale as an indicator of the level of transitory anxiety experienced by clients in counseling, psychotherapy, behavioral therapy, or on a psychiatric ward. The instrument has proven to be an effective measure of changes in A-State intensity which occurs in treatment situations (Spielberger et al., 1970).

Katkin (1978) highly recommended the usage of the STAI for the clinical psychologist and/or personality researcher. He stated that it is an easy-to-administer, easy-to-score, reliable, and valid index of either individual differences in proneness to anxiety or individual differences in transitory experience of anxiety. He added that the test is carefully described in the manual, there is voluminous research literature attesting to its reliability and validity in a variety of contexts, and the test is grounded well in theory. One more advantage is the convenience with which one can measure both trait and state concepts of anxiety.

In comparing and contrasting the STAI with other measures of anxiety, Levitt (1980) indicated that this instrument is the most recent of the popular general trait anxiety measures. One of the assets of this instrument is that it has been tested in a wide variety of experimental and applied situations and has undergone several revisions. Another advantage of the STAI over other anxiety measures is that it is the only anxiety inventory that has both a trait and a state form. Levitt also pointed to another important characteristic of the trait form. It was found that it is unaffected by immediate stress. Such stability is lacking in other measures of trait anxiety.

In sum, Levitt (1980) concluded that the "STAI is probably the most carefully developed and rigorously examined instrument that has yet appeared" (p. 55).

Although the advantages of the inventory outweigh its disadvantages, there are problems inherent in this method of data collection, such as response set and social desirability. Dreger (1978) noticed that the STAI is open to faking to a greater extent than more subtle pencil-and-paper tests.

Spielberger et al. (1977) pointed to the shortcomings of self-report measures such as the STAI. First, the use of introspective reports is based on the assumption that people are capable of distinguishing between different feeling states and that they are motivated to report accurately and honestly. A counter argument to this assumption may be that people do not know themselves well enough to give truthful answers or that many people are not willing to share negative things about themselves. Second, as far as the issue of objectivity of self-report measures is concerned, it may be argued that self-report measures are not different from projective tests in the sense that the items may be perceived as ambiguous and, hence, mean different things to different people.

Spielberger et al.'s (1977) answers to these questions are: (1) administration of the STAI scale for clinical and research purposes has shown that adolescents and adult with at least dull-normal intelligence are capable of describing how they feel at a particular moment in time; (2) most people are willing to reveal how they feel during a therapy hour or while performing on an experimental task, provided that

they are asked specific questions about their feelings and the feelings were recently experienced.

Description

The STAI is a paper-and-pencil, self-report measure of both state (A-state) and trait (A-trait) anxiety.

The STAI A-trait scale consists of 20 statements that ask people to describe how they generally feel. Subjects respond to each A-trait item (e.g., "I feel pleasant") by rating themselves on the following 4-point scale: (1) almost never, (2) sometimes, (3) often, and (4) almost always.

The STAI A-state scale consists of 20 statements that ask people to describe how they feel at a particular moment in time--how they feel right now, that is, at this moment. Subjects respond to each A-state item (e.g., "I am tense") by rating themselves on the following 4-point scale: (1) not at all, (2) somewhat, (3) moderately so, and (4) very much so.

The main components of A-state scale involve feelings of tension, nervousness, worry, and apprehension. Also, items which indicate the absence of feelings of calmness, security, contentment, and the like were included. Items were presented in substantively counter-balanced order relative to anxiety. The scoring keys reverse the direction of the nonanxiety items so that a high scores suggests high states of anxiety. Thus, the STAI A-state scale defines a continuum of increasing levels of A-state intensity, with low scores indicating states of calmness and serenity, intermediate scores indicating moderate levels of tension and apprehension, and high scores reflecting states of intense

apprehension and fear that approach panic (Spielberger, Lushene, & McAdoo, 1977).

Within the possible score range of 20-80, normal subjects average between 35 and 40 on the STAI and psychiatric patient groups average about 10 score points higher.

Reliability

Test-retest reliability data on STAI was gathered from a sample of undergraduate college students. The test-retest correlations for the A-Trait scale were relatively high, ranging from .73 to .86, while those for the A-State scale were relatively low, ranging from .16 to .54, with a median r of only .32 for the six subgroups (Spielberger et al., 1970). The others stated that the low rs for the A-State scale were anticipated because a valid measure of A-State should reflect the influence of unique situational factors existing at the time of testing.

Alpha coefficients for the STAI scales were employed as a measure of internal consistency. The reliability coefficients ranged from .83 to .92 for A-State and from .86 to .92 for A-Trait. Thus, the internal consistency of both STAI subscales was reasonably high (Spielberger et al., 1970).

Spielberger et al. have indicated that Alpha reliability coefficients were typically higher for the A-State scale when it is given under conditions of psychological stress. They reported that the Alpha reliability of the scale was .92 when it was administererd to a group of college males immediately after a difficult intelligence test, .89 when it was given following a brief period of relaxation training.

Validity

Correlations with the IPAT Anxiety Scale (Cattell & Scheir, 1963), the Taylor (1953) Manifest Anxiety Scale (TMAS), and the Zuckerman (1960) Affect Adjective Checklist (AACL), General Form provide evidence of the concurrent validity of the STAI A-Trait scale. The correlations between the STAI, the IPAT, and the TMAS were moderately high for both college students and patients. They ranged from .75 to .83. Based on these intercorrelations, it was concluded that the three scales can be considered as alternate measures of A-Trait (Spielberger et al., 1970).

Evidence of the concurrent validity of the STAI A-State was obtained by correlating the A-State scale with other measures of A-State, such as the Zuckerman (1960) Affect Adjective Checklist, Today Form (Spielberger et al., 1970).

Evidence of the construct validity of the STAI A-State scale was provided by demonstrating that scores on the A-State scale increased in response to various kinds of stress and decrease as a result of relaxation training (Edwards, 1969; Hodges & Felling, 1970; O'Neil et al., 1969; Parrino, 1969; Spielberger et al., 1970; Spielberger et al., 1972; and Taylor, Wheeler, & Altman, 1968). More important, however, was that in the construction of the STAI, individual items were required to meet prescribed A-State validity criteria at each stage of the test development process in order to be retained for further evaluation and validation (Spielberger et al., 1968).

Background Information Questionnaire

The questionnaire was designed particularly for the purpose of this study. The instrument consisted of 29 items and was divided into two parts:

1. Personal demographic data about the abused women and women in the control group. It provided information in regard to several variables such as age, race, marital status, education, income, employment status, health, drug use, etc. This section included 15 items. The last question of this part was about the presence of physical abuse in a respondent's current relationship with her partner. The purpose of asking this question was to insure that none of the women in the control group was battered and also to confirm that each woman in the experimental group had been physically abused by her current partner.

2. The second part of the questionnaire was aimed at exploring the nature of the battering experience. Fourteen items were selected to measure past history of abuse, abuse in the family of origin, frequency, duration, and severity of abusive events.

Questions 16, 20, and 21 were used to measure frequency of abusive incidents. Frequency scores range from 2 to 15 so that the higher scores indicated a higher frequency. A sample question from the questionnaire is

1. Prior to this incident, how many times were you physically abused?
    1. 1-5 times
    2. 6-10 times
    3. 11-25 times
    4. 26-50 times
    5. 51-100 times

The duration variable was measured similarly. Three items were devoted to this purpose. The response range was from 3 to 19 so that the higher the score, the longer the duration. A sample question is

1. How long have you been in this battering relationship since the occurrence of the first abusive incident?
    1. Less than 6 months
    2. 6 months to 1 year
    3. 1-2 years
    4. 2-4 years
    5. 4-6 years
    6. 6-10 years
    7. More than 10 years

Also, three questions were used to measure severity of abusive behavior (see questions 22, 23, 24, Appendix A). The scores ranged from 2 to 15 so that the higher the score, the more intense the severity.

All of the questions except one were close-ended. The last item was an open-ended one. Its exact wording is as follows:

29. What made you leave your partner and come to the shelter at this particular time?

The items were derived from different sources. Four of the items were chosen from a 12-page survey questionnaire designed by Pagelow (1980) which aimed at obtaining a maximum amount of information from victims of abuse. Another seven items were selected from a self-administered questionnaire designed by the Illinois Coalition Against Domestic Violence. Question 23 was borrowed from Straus (1977-78) as a measure of the extent/severity of violence. Straus labels it the Physical Violence Index. It contains the following eight items: (1) throwing things at the spouse; (2) pushing, shoving, or grabbing; (3) slapping; (4) kicking, biting, or hitting with the fist; (5) hit, or try to hit, with something; (6) beat up; (7) threatened with a knife or gun; (8) used a knife or gun.

The rest of the questions, 17 in number, were written by the author for the purpose of this study. The questionnaire was reviewed by three psychologists who had experience working with battered women. Some of the questions were modified; others were eliminated on the basis of the reviewers' consensus.

Evaluation Form of Shelter Experience

The questionnaire contains 10 items. The first four questions aim at obtaining information regarding battered women's past experience in seeking help from shelters (see Appendix A). The rest of the questions focus on the subjective experience of battered women at the shelter. The main purpose of gathering data in this area is to get firsthand information from the victims themselves about their needs and the services they valued most while residing at the shelter.

The format of this questionnaire is a combination of both open- and close-ended questions. A sample item of this section is

1. What was most helpful in being at this shelter?

CHAPTER IV
RESULTS

Background Characteristics

Age

The average age of battered and nonbattered women is very similar. Almost 60% of the women in both groups fall within the 20-29 year age bracket. The remaining 40% of the battered women group fall into the following age brackets: 2.5% are under 20 years of age, 32.5% are between 30 and 39 years of age, and 7.5% are between 40 and 49 years of age. In contrast, the age range of the non-battered women group is somewhat wider. Approximately 7% are under 20 years of age, 23.3% fall into the 30-39 category, 3.3% are in the 40-49 age group, and the remaining 6.7% are between 50 and 59 years of age. However, there seem to be some differences between the two groups regarding the age of marriage. Although a high proportion of the battered women, 42.5%, were married at or below the age of 20, only 10% of the non-battered women tended to marry that young. Meanwhile, a sizable proportion of the two groups appear to marry at a somewhat older age. Fifty percent of the battered women group compared to 47% of the non-battered women were married around the 21-30 year age bracket.

Marital Status

The majority of battered women were currently married. Fifty-three percent were married for the first time, and another 13% were

remarried. The remaining 34% were living with a man. The marital status makeup of the control group was somewhat different. The range was wider. Thirty-seven percent were married for the first time, 20% were living with a man, 3.3% were divorces, and another 6.7% were legally separated. One-third of the control were single women who were involved in a long-term relationship.

The abused and non-abused women groups appear to be similar in terms of the average length of their marital/cohabiting relationships. The range of stay was between 1-20+ years; however, the mean length of both groups is in the 1-10 year range. However, while 70% of the battered women have spent 1-5 years in their current relationships, only 46.7% of the control group women have done so. The remaining 30% of the experimental group, in comparison with 16.6% of the control group, were involved in relationships that ranged from 6 to over 20 years.

Race

The racial composition of the two groups was significantly diferent. The vast majority of the battered women group were women of color and Third World women: 75% were blacks, 5% were Hispanic, 2.5% were Asians, and the remaining 5% listed themselves as others. Only 12.5% of the battered group were Caucasian.

Women in the control group were almost equally distributed between the two major categories. Caucasians accounted for 46.7%, blacks accounted for 50%, and Hispanic respondents accounted for 3.3% (see Table 2).

TABLE 2
RACIAL COMPOSITION OF THE SAMPLE

Race	Battered Women		Non-Battered Women	
	N	%	N	%
Caucasian	5	12.5	14	46.7
Black	30	75.0	15	50.0
Hispanic	2	5.0	1	3.3
Asian	1	2.5	-	-
Other	2	5.0	-	-
Total	40		30	

Note: Other includes one black African woman and one Haitian woman.

Income

The average annual income of the battered and non-battered group women is similar. While the average personal earnings of women in the two groups fall into the $7,000-14,999 bracket, the family income is higher for both groups and is within the $10,000-or more range (see Table 3).

Employment

Most of the women were employed either full or part time. While 63.3% of the control group women were engaged in full-time jobs, only 47.5% of the battered women worked full time. Also, the rate of women who tend to work part time was higher in the control group.

The difference between the two groups seemed to be most apparent in the area of unemployment. Unemployment was much higher in the battered women group. Twenty-five percent of the battered group women, in comparison to only 3.3% of the control group women were unemployed. Additionally, housewives accounted for 15% of the battered women in comparison to 3.3% of the women in the control group. Therefore, 40% of the battered women compared to 6.6% of the nonbattered women did not earn any income during the last year.

Education

Overall, control group women tend to be more educated than battered group women. While the average educational level of the battered group women is slightly over the postsecondary level, women in the control group seem to be more highly educated, with an average education that falls within the some college to a college degree. In general, it

TABLE 3
PERSONAL AND FAMILY INCOMES OF THE SAMPLE

Income (in %)	Battered Women				Non-Battered Women			
	Personal Income		Family Income		Personal Income		Family Income	
	N	%	N	%	N	%	N	%
Under 3,000	7	17.5	1	2.5	3	10.0	0	0.0
3,000-4,999	5	12.5	1	2.5	3	10.0	1	3.3
5,000-6,999	2	5.0	1	2.5	3	10.0	0	0.0
7,000-9,999	6	15.0	2	5.0	4	13.3	1	3.3
10,000-14,999	4	10.0	7	17.5	5	16.7	4	13.3
Over 15,000	7	17.5	11	27.5	11	36.7	21	70.0
Not applicable	9	22.5	17	42.5	1	3.3	3	10.0
Total	40		40		30		30	

is noticeable that the two groups represent women from varied educational backgrounds. The educational level extends from as low as grammar school for some women to as high as holding a graduate degree for others (see Table 4). More specifically, a very small number of battered women, 2.5%, had finished grammar school only. While another 17.5% had not finished high school, 25 percent of the victims were high school graduates; almost 43% had some college or vocational training; only 2.5% graduated from college; 10% of the victims were either graduate students or had graduate degrees. A very different pattern existed among the control group women. The educational attainment of this group seems to be skewed toward the upper limit of the continuum. Only 6.7% had some high school; 10% finished high school; 3.3% had some vocational training; 16.7% had some college, 23.3% had college degrees; 20% were graduate students; and the remaining 20% had graduate degrees.

Children

The two groups are strikingly different in respect to the number of children the women tend to have. Almost 88% of the battered women, compared to 17% of the control group women reported having children.

The average number of children in the experimental group is 1.9, in comparison to 0.4 children in the control group. Two women in the battered women group, in comparison to only one woman in the control group, have five or more children.

As indicated in Table 5, 50% of the children of battered women tend to be under the age of 6, while only 33% of the children of the women in the control group constitute the 1-6 age group.

TABLE 4
EDUCATION BY GROUP

Education	Battered Women		Non-Battered Women	
	N	%	N	%
Grammar school or less	1	2.5	0	0.0
Some high school	7	17.5	2	6.7
High school graduate	10	25.0	3	10.0
Postsecondary	6	15.0	1	3.3
Some college	11	27.5	5	16.7
College degree	1	2.5	7	23.3
Some graduate school	1	2.5	6	20.0
Graduate school	3	7.5	6	20.0

TABLE 5
CHILDREN BY AGE AND BIRTH ORDER

Children	1-6 Years		7-12 Years		13-18 Years		Over 19 Years	
	Battered	Control	Battered	Control	Battered	Control	Battered	Control
1st child	19	4	10	0	4	0	2	2
2nd child	11	0	5	0	6	0	1	2
3rd child	4	0	2	0	2	0	2	1
4th child	4	0	1	0	0	0	1	1
5th child	1	0	0	0	0	0	1	1
6th child	0	0	0	0	0	0	1	0

Health

While the largest proportion of battered women, 55%, perceive the general condition of their health to be within the average range, 60% of the control women describe their health as excellent. Additionally, it is noted that 15% of the battered women believe that their health is poor. But none of the control group women perceives herself as having poor health.

When they were asked specifically whether they suffer from any kind of chronic physical condition, 37% of the battered women complained of at least one illness. Migraine headaches, 12.5%; high blood pressure, 12.5%; and abdominal pain, 7.5%, were the most frequently indicated pathologies.

The response of women in the control group to this question is somewhat different. Only 16.7% acknowledged the presence of chronic illness. Almost 7% complained of migraine headaches; 3.3% had high blood pressure; 3.3% suffered from arthritis; and 3.3% had anemia.

Drugs and/or Medication

Although most of the women in the sample reported that they did not use drugs or medication on a regular basis, some of them tended to take drugs regularly. There is a small difference between the two groups in regard to drug consumption. Eighty-three percent of the women in the control group, in comparison to 75% of the battered women, denied taking drugs or medication. However, 25% of the women in the battered group compared to 17% of the control group are regular users of drugs and/or medication. In the battered women group, 5% of the women used marijuana; 7.5% took minor tranquilizers; 2.5% took major tranquilizers;

12.5% used other prescribed drugs. The percentages of women in the control group who used marijuana, sleeping pills, and other kinds of medication were 3.3%, 3.3%, and 10%, respectively.

Summary

The majority of women in the two groups were 20-30 years of age, with a greater tendency of battered women to marry at a younger age. The average length of their current relationships is also similar and falls within the 1-10 years range. They tend to be employed, with an average personal income that is slightly beyond the $7,000-9,999 range. The majority of women in both groups abstain from using drugs and/or medication, but a relatively high proportion of both groups are regular users of drugs and/or medication.

The abused women are predominantly black, have more children, and are less educated than their counterparts in the control group.

Inter-Group Differences on Background Variables

In order to determine whether the two groups differed significantly in their demographic background, a series of *t*-tests and Chi-square tests was performed and the results are presented in Table 6 and Table 7. Note that, due to the large number of statistical tests being conducted, $p < 0.01$ has been chosen as the criterion level of statistical significance to avoid interpreting chance differences as significant.

Results revealed significant differences between battered and non-battered women only on four out of the twelve background variables. Inspection of means and percentages indicates that battered women in

TABLE 6
COMPARING BATTERED AND NON-BATTERED WOMEN ON SELECTED DEMOGRAPHIC VARIABLES USING T-STATISTICS

Demographic Variable	Group	t-Statistics	p-Value	Mean
Age	Battered	0.09	0.93	2.45
	Non-battered			2.43
Length of relationship	Battered	0.41	0.68	1.60
	Non-battered			1.73
Age when married	Battered	-1.97	0.06	1.65
	Non-battered			2.00
Education	Battered	-4.13*	0.001	4.02
	Non-battered			5.80
Personal income	Battered	-.34	0.73	4.23
	Non-battered			4.40
Family income	Battered	0.21	.83	5.78
	Non-battered			5.72
Physical health	Battered	1.88	0.06	1.30
	Non-battered			1.03
Drug intake	Battered	0.98	0.32	0.27
	Non-battered			0.16
Number of children	Battered	4.83*	0.001	1.92
	Non-battered			0.40

*$p \leq 0.05$.

TABLE 7
MORE DEMOGRAPHIC COMPARISONS BETWEEN BATTERED AND NON-BATTERED WOMEN USING CHI-SQUARE STATISTICS

Demographic Variable	Battered Women		Non-Battered Women		Chi-Square	p-Value
	N	%	N	%		
Marital status						
Married	26	65.0	11	36.7	21.28*	0.0001
Unmarried[a]	-	-	13	43.3		
Living with mate	14	35.0	6	20.0		
Race						
Caucasian	5	12.5	14	46.7	10.11*	0.001
Women of color[b]	35	87.5	16	53.3		
Employment						
Employed part-time	4	10	6	20.0	5.63	0.059
Employed full time	19	47.5	19	50.0		
Unemployed[c]	17	42.5	5	16.7		

[a]Unmarried category includes women who are widowed, divorced legally separated, and single.

[b]Women of color are black, Hispanic, Asian, and African Third World women.

[c]Unemployed include housewives, unemployed, and students.

*$p \leq 0.05$.

this sample are more likely to be less educated. They tend to have more children. They show greater tendency to be married or living with a partner. Also, they tend to be part of an ethnic minority. In contrast, non-battered women are likely to be more educated, have fewer children, be unmarried, and Caucasians.

The Nature of Violence

History of Violence

Five questions were asked which explored the nature of the battered women's experience in domestic violence (see Appendix A, questions 25, 25b, 26, 26b, 27). Findings indicated that 22.5% of the battered women have previous experience in violent adult relationships. These women were predominantly victims of male aggression. More specifically, ex-boyfriends and ex-husbands accounted for 12.5% of the abusers. Another 2.5% were abused by a male relative, and an additional 2.5% reported being abused by both a father and an ex-husband. However, only 5% reported being abused by their mothers.

When women were asked about their childhood experience of abuse, affirmative responses were elicited from 20% of the sample. Mothers were identified as child abusers in 12.5% of the cases. The remaining 7.5% were equally divided between three categories of abusers: father, stepfather, and mother's boyfriend. One may conclude that 20% of the battered women were physically abused as children by a parental figure.

Duration

One of the strikingly interesting features of the present sample of abused women as opposed to other studies of battered women is the relatively short duration of their battering relationships. The average

stay in the relationship since the first incident of abuse had occurred, fell within the 1-4 year range. In fact, 75% of the cases were distributed among the first four categories of "length of the battering relationship" variable. Stated in other words, 75% of the women endured battering relationships which lasted from less than 6 months to 4 years. Of course, there were women who represent the other end of the spectrum. For instance, five women reported being abused for over 10 years.

The length of the first abusive incident seems to be somewhat shorter than the average duration of the subsequent attacks. For example, while 40% of the women reported that the average length of the attacks was 15-60 minutes, only 22.5% indicated that the first incident lasted for that period of time. In most cases, the first attack was described as very brief, shocking, and did not exceed 15 minutes. In fact, 28% of the women stated that the first incident was less than 5 minutes long.

Frequency

The majority of battered women, 70%, reported that abuse became more frequent over time. Another 15% indicated that they were not sure whether or not violence escalated with time. The remaining 12.5% were not able to detect any pattern of increasing abuse as an outcome of prolonged relationships.

Almost 50% of the sample experienced abuse on a regular basis, with frequency of several times a month. Another 22.5% of the battered women experienced abuse several times a week. It is noted that a small minority occupied the two extreme points of the continuum. While 5%

reported being physically abused on a daily basis, another 5% indicated that they had only had one violent experience with their partners.

The question of frequency was also measured in terms of the number of times each woman was physically attacked. It is noted that the women were almost equally distributed among the five different categories. For instance, while 20% of the women fell within the lowest frequency category of 1-5 times, another 20% were in the highest frequency group of 51-100 physical attacks. There was little variation in frequency in the remaining three categories, with reported percentages of 22.5% in the 6-10 times group, 15% in the 11-25 times group, and 17.5% in the 26-50 times group.

Severity

The response to one of the severity questions indicated that a pattern of severity of abuse was established in the relationship. Almost 70% of the battered women observed that the abusive attacks tended to intensify the longer they stayed with their partners. Another 15% were not sure whether a relationship existed between intensity of abuse and length of time spent in the relationship. The remaining 15% did not notice whether injuries became more serious over time.

Two additional questions were used to assess the severity of violent acts (see Appendix A, questions 23, 24). Data from question 23 revealed that battered women were subjected to a wide range of aggressive behavior. All of them were the recipients of more than one form of physical violence. Although some types of violent acts were more frequently used than others, a relatively high proportion of women fell within each dimension of the severity scale.

The most commonly practiced forms of violence in this sample were "kicking, biting, or hitting with fist," with 75% of the women reporting experiencing one of these acts. The second most "popular" acts were "pushing, grabbing, and shoving"; at least one of these was reported by 70% of the women. However, a relatively large number of women experienced more dangerous acts. For instance, 45% reported being threatened with a knife or gun, and another 22.5% were actually knifed or shot at by their partners.

The final measure that was used to evaluate the extent/severity of abuse was the type of injury and whether or not women had sought medical attention. The results indicate that the most frequently detected physical injury was described as "scrapes, bruises, and cuts." Approximately 50% of the battered women indicated that they sought medical attention for this injury, and another 50% indicated that they did not. The second most common response was "injury needing hospitalization," which was indicated by 27.5% of the women in this sample. None of the battered women gave the "not sure" response for assessing their injuries.

Group Differences in Depression and Anxiety

The mean values of 36 battered and 30 non-battered women were examined to see whether there are significant differences between the two groups on their response to the Beck Depression Inventory and the State Trait Anxiety Inventory. The first hypothesis predicted that the battered women group is more likely to constitute a high-risk population for both depression and anxiety. It was expected that the abused women will be more depressed and anxious than the non-abused women. Since the

battered and non-battered women were significantly different in some aspects of their demographic backgrounds, a general linear model analysis was employed to control for the individual and combined effects of race, education, marital status, and number of children.

After adjustment by linear components of transformed covariates, the battered and non-battered women differed significantly with respect to depression, state, and trait anxiety. As demonstrated in Table 8, $F(1,65) = 37.15$, $p < 0.05$ for depression; $F(1,65) = 28.13$, $p < 0.05$ for state anxiety; and $F(1,63) = 16.01$, $p < 0.05$ for trait anxiety. A closer examination of adjusted means, as displayed in Table 9, reveals that the differences were in the predicted direction. Battered women evidenced higher rates of depression, state, and trait anxiety. The depression scores of the battered women group suggest that they fall within the moderately-severely depressed category. In fact, most of the battered women scored toward the moderately depressed end of the category. In contrast, the scores of the non-battered women group fell within the normal range of 0-9, which is not indicative of depression. Therefore, one may conclude that the tendency of battered women to be more depressed and experience higher levels of transitory anxiety and trait anxiety is not due to the fact that they are less educated, women of color, married, and having more children than women in the control group. It seems that the differences in depression and anxiety can largely be attributed to the independent variable of battering.

TABLE 8
ANALYSIS OF COVARIANCE: DEMOGRAPHIC VARIABLES AS DETERMINANTS OF DEPRESSION AND ANXIETY

Instrument	Source of Variation	F-Statistics	p-Value
BDI 1	Covariates	6.69	0.0001*
	Race	5.78	0.01*
	Education	5.12	0.02*
	Marital status	0.86	0.35
	Children	3.74	0.05*
	Main effects		
	Battering	37.15	0.0001*
State 1	Covariates	2.21	0.07
	Race	3.55	0.06
	Education	1.51	0.22
	Marital status	0.27	0.60
	Children	4.69	0.03*
	Main effects		
	Battering	28.13	0.0001*
Trait 1	Covariates	1.05	0.38
	Race	2.36	0.13
	Education	0.30	0.58
	Marital Status	0.47	0.49
	Children	1.21	0.27
	Main effects		
	Battering	16.01	0.0001*

*$p \leq 0.05$.

TABLE 9
GROUP DIFFERENCES ON THE BDI AND STAI PRETEST SCORES

Inventory	Group	SD	Sample Means	Adjusted Means
Beck Depression Inventory	Abused	10.55	21.68	21.84
	Non-abused	4.53	5.70	5.51
State Anxiety	Abused	13.24	51.75	53.66
	Non-abused	9.68	36.56	34.28
Trait Anxiety	Abused	12.63	47.35	49.05
	Non-abused	8.58	36.60	34.67

Note: The possible range of scores on the BDI is 0-63; on the STAI it is 20-80. Categorization of the BDI scores was presented in Chapter 3.

In order to have a better sense as to the meaning of anxiety scores of battered and non-battered women, a decision was made to compare the results of this study with the normative findings of Spielberger et al. (1970). Notice that there is no available normative data on the BDI. The means and standard deviations in the five samples are presented in Table 10. To examine whether or not the means of the five samples are significantly different, one-way analysis of variance was performed. Results of this analysis revealed that the difference in sample means is significant for both trait and state anxiety with $F(4,918) = 24.53$, $p < 0.05$ for the trait anxiety and $F(4,918) = 47.24$, $p < 0.05$ for the state anxiety.

Since significant differences were obtained, pairwise comparisons of groups were performed. Newman-Keuls test was used to test the difference of means in trait and state anxiety obtained from each group. A summary of the tests of significance for the trait anxiety revealed that the battered women and the neuropsychiatric patients significantly differed from the non-battered women and the undergraduate females, but they were not significantly different from each other and from the general medical and surgical patients. In addition, there was no significant difference between the undergraduate females and the non-battered women. Also, there was no significant difference between the general medical patients and both the non-battered women and the undergraduate females.

Relatively speaking, similar trend was observed in the results of state anxiety. The battered women, neuropsychiatric patients, and general medical patients differed significantly from the non-battered

TABLE 10
STAI MEANS AND STANDARD DEVIATIONS FOR NORMATIVE, BATTERED, AND NON-BATTERED SAMPLES

	A-Trait		A-State		N
	Mean	SD	Mean	SD	
Undergraduate females*	38.25	9.14	35.12	9.25	231
Neuropsychiatric patients*	46.62	12.41	47.74	13.24	461
General medical and surgical patients*	41.91	12.70	42.38	13.79	161
Battered women**	47.35	12.63	51.75	13.24	40
Non-battered women**	36.60	8.58	36.56	9.68	30

*Normative data from Spielberger et al. (1970).

**Data from present study.

women and the undergraduate females, but there was no significant difference among the first three groups and no difference between the non-battered women and the undergraduate females. For more deteails, see Table 11.

To sum up, results of state and trait anxiety reveal striking similarity between the battered women and the medical and neuropsychiatric patients. Meanwhile, the mean scores of the non-battered women could be classified under the umbrella of "normal" state and trait anxiety.

Pretest-Posttest Results on Depression and Anxiety

The second hypothesis examines the impact of treatment received at the shelter on depression, state, and trait anxiety. It was hypothesized that the treatment would produce changes favoring the experimental group over the control group. It was expected that, as a result of staying at the shelter, the scores of the battered women would decrease, while the scores of non-battered women would remain at about the same initial level. To test this hypothesis, it is necessary to rule out the significant effects of the pretest results on depression and anxiety. In addition, the question arises as to whether the obtained posttest results would be attributed to the independent variables of battering and sheltering, or if they would be explained by other differences that exist between the two groups. Since there were significant differences between the two groups in terms of education, marital status, race, and number of children, would these variables contaminate the posttest findings? If we rule out the effects of these four variables, would we

TABLE 11
TESTS ON DIFFERENCES BETWEEN ALL PAIRS OF MEANS

Instrument	1	2	3	4	5	Newman-Keuls Test*
Trait anxiety	38.25	46.62	41.91	47.35	36.60	5 1 3 2 4
State anxiety	35.12	47.74	42.38	51.75	36.56	1 5 3 2 4

Note. 1 = undergraduate females; 2 = neuropsychiatric patients; 3 = general medical and surgical patients; 4 = battered women; 5 = non-battered women.

*Means underlined by a common line do not differ; means not underlined by a common line do differ.

still obtain significant differences between the battered and non-battered women in terms of posttreatment depression and anxiety.

To answer the question on the impact of significant demograhic variables on posttest results, a Pearson Product-Moment Correlation was computed. The rationale for using this analysis was to determine whether or not these four demographic variables correlate significantly with the dependent variables of posttest depression and anxiety. If the results reveal significant correlations, then a general linear model analysis would be used in order to control for these demographic differences between the two groups. If the results are not significant, then no further analysis would be desired. This process of decision making as to when and what statistical procedures should be employed is recommended by Cohen and Cohen (1975, p. 377).

Results reveal that all the correlations between the four demographic variables and the posttest scores on depression, state, and trait anxiety were weak, negligible, and insignificant. They ranged from $\underline{r} = 0.02$, $\underline{p} < 0.42$ to $\underline{r} = 0.26$, $\underline{p} < 0.06$. For more detailed information, consult Table 12. Based on these results, an analysis of covariance using the four demographic variables as additional covariates does not seem to be required. However, as a check on the Cohen and Cohen position, the more extensive analysis was carried out with results identical to the analysis reported below.

Therefore, in order to examine whether the posttest scores were contaminated by the significant initial differences on depression and anxiety, an analysis of covariance was employed. As demonstrated in Table 13, results reveal that, when the pretest means were controlled,

TABLE 12
CORRELATIONS BETWEEN POSTTEST MEASURES AND SIGNIFICANT DEMOGRAPHIC VARIABLES

	Beck 2	State 2	Trait 2
Education	-0.23	-0.16	-0.22
Marital status	-0.07	0.02	0.26
Number of children	0.11	0.16	0.07
Race	0.22	0.18	0.11

TABLE 13
PRETEST MEANS AS DETERMINANTS OF POSTTEST CHANGES IN DEPRESSION AND ANXIETY

Instrument	F-Statistics	p-Value
	Covariate:	
	Beck 1 : 36.73	0.0001*
Beck 2	Main effects : 0.30	0.58
	State 1 : 17.28	0.0001*
State 2	Main effects : 4.61	0.03*
	Trait 1 : 67.34	0.0001*
Trait 2	Main effects : 0.56	0.45

*$p \leq 0.05$.

the differences between the battered and non-battered women groups on posttest depression and trait anxiety did not hold up. Yet, the two groups continued to differ significantly on the posttest scores on state

anxiety. These results suggest that the treatment received at the shelter does contribute to changing the state anxiety of battered women in the desired direction, but does not play a significant role in reducing trait anxiety and depressive symptomatology.

However, a close examination of the pre- and posttest adjusted means on depression and trait anxiety reveals that the battered women group showed more improvement from pre- to posttesting. It should be noted that, although these changes were not statistically significant, they were in the predicted direction (see Table 14).

To sum up, based on the results of Pearson Product-Moment Correlations and analysis of covariance, one may conclude that the obtained significant result of pre- and posttest change in state anxiety can be attributed to the independent variable of sheltering, rather than to race, marital status, education, and number of children.

Hypothesis Number Three

Finally, to analyze the nature of the relationship between depression and anxiety and the three dimensions of battering, a Pearson's Product Moment Correlation was computed. A "total duration score" was obtained by combining the scores from the three items measuring this variable. Similarly, the "frequency index" and the "severity index" were obtained.

It was hypothesized that there would be a positive and direct relationship between depression and anxiety and the duration, frequency, and severity of abuse. This hypothesis was confirmed in only one instance. There was a significant correlation between the severity of abuse and the posttest scores of depression. The value of $r = .38$,

TABLE 14
PRETEST AND POSTTEST MEANS OF DEPRESSION AND ANXIETY

Instrument	Battered Women			Non-Battered Women		
	SD	Sample Mean	Adjusted Mean	SD	Sample Mean	Adjusted Mean
BDI 1	11.32	22.00	21.84	3.68	5.55	5.51
BDI 2	9.71	11.28	9.50	3.16	4.00	4.25
A-State 1	12.67	50.38	53.66	8.88	35.72	34.28
A-State 2	10.47	42.71	41.34	5.75	31.88	30.85
A-Trait 1	11.01	44.04	49.05	7.67	37.66	34.67
A-Trait 2	10.22	40.19	38.44	7.40	34.05	34.67

Note. N = 21 battered, 18 non-battered.

$p < .03$ is in the predicted direction. The remaining correlations were weak, negligible, and insignificant. They ranged from .005 to -.15.

Why Did She Leave?

In order to understand the conscious motives of battered women for leaving the abusive relationship, a specific and direct question was asked: "What made you dedide to leave your partner at this particular point in time?"

Information regarding this question was gathered from 32 women. Most of them indicated more than one reason for leaving. They reported that it was a combination of several important factors that led them to make their final decision. More precisely, the range of responses was from one to eight, with an average of four reasons provided by each woman. Only four of the women reported one major factor for leaving the abuser. In all other cases, two or more reasons were given.

Reponses were classified into 17 categories, since the question was open ended. The reasons for leaving are listed in Table 19 according to a descending rank order.

The list of reasons reported by women for leaving the relationship is relatively long. The rationale for including popular, as well as distinct, responses is that it may shed some light on both the commonalities of the precipitating events and the uniqueness of each case. Therefore, rather than losing pertinent information by creating broad categories, one may gain a more comprehensive picture of individual differences regarding women's reasons for leaving their partners.

The most commonly stated cause for severing the relationship is the women's determination to stop tolerating abuse and harassment. They

TABLE 15
REASONS FOR LEAVING

	Reported Reason	N	%
1.	Commitment toward no more abuse	22	55.0
2.	Fear of being killed	19	47.5
3.	Giving up all hope for change	10	25.0
4.	Escalation of verbal and emotional abuse	9	22.5
5.	Realization that she is able to survive on her own	8	20.0
6.	Being informed about the existence of shelters	8	20.0
7.	Attitude shifted from saving the family towards rescuing self	8	20.0
8.	Realization that husband's beating is arbitrary and abrupt	7	17.5
9.	Violence started to affect the children	7	17.5
10.	Lack of financial support by partner	6	15.5
11.	Fear of killing partner	5	12.5
12.	Expansion of his violence and/or threat of violence toward children	5	12.5
13.	Severity and/or frequency of abuse	4	10.0
14.	He put her out	4	10.0
15.	Loss of family support	3	7.5
16.	Expansion of violence toward her family	3	7.5
17.	His involvement with another woman	3	7.5

Note: N = 32 battered women.

indicated that they wanted to start a new life which would be free of violence. For instance, many of the victims said: "I am fed up," "I got tired of it," "I have the right not to be abused," "I got tired of feeling unhappy," "I got tired of being isolated," "I got tired of reporting to him," "I cannot stand more beatings," and "I got tired of not having control."

The second most popuplar response was the fear of being killed. Almost half of the sample reported sensing a real danger in staying with their partners. Their fear of the lethality of violence seemed to indicate a realistic and appropriate assessment of their domestic situation, particularly when one considers that 45% of the men had threatened their wives with a knife or gun and 22.5% had already used a knife or gun. In fact, one of the respondents was shot at by her boyfriend in 1974. As a result, she suffers from epilepsy and has "handicapped legs" and "stiff hands." However, 3 months after the incident she went back to him because "He told her over and over again that he wanted her back in the house, his family begged her to return, and her child wanted a mother and father together." She reported that he had not beaten her since that incident. However, shortly before she came to the shelter he shot the neighbor's wall while she was visiting them. Interestingly enough, this incident was not the precipitating factor for her leaving and seeking help from the shelter. The victim did not view the experience as traumatic. She talked about it as "a matter of fact" without showing any affect. She indicated that the shooting did not bother her much. Her primary concern was that his family held her responsible for his behavior and she believed that she had consequently lost them and their

support. The woman did not press charges in either incident. Furthermore, as she evaluates the dynamics of violence in her family, she concludes: "If he puts his hands on me I deserve it . . . when I think back about it I see that I pick on him, I bug him."

Another resident who is a 29-year-old black female, mother of four children and pregnant at the time of the interview, stated that when the last argument escalated, her husband threatened to pour boiling water over her if she refused to tell him whom she was talking to on the phone. He proceeded to say: "You do not need to be here, you need to be somewhere else. . . . I have been in jail for 10 years and I would kill again." He took her keys, put her out, and asked her to leave. This same man became a regular caller to the shelter, threatened to invade the place, and tried to commit suicide when he felt that his wife was very determined about terminating their relationship.

A classical response was presented by Debby, who stated: "When he got the gun, I knew it was time for me to go for good."

Pat reported that she left because her husband threw her off the balcony. She "never wants to chance her life with him again."

Violence does seem to generate violence; and while it was not one of the primary reasons given for leaving, 12.5% of the women indicated that they left because they were afraid of their own impulses. They reported that they felt that they might kill their husbands if they stayed with them. One of the women stated: "I did not want to lose control; I did not want to strike back because if I do I am lethal . . . my anger and rage can burn the whole city."

The third most frequently stated reason for leaving is the sense of hopelessness women experience regarding changing the abusive

behavior. They feel that he is likely to beat them again and again. Twenty-five percent of the women decided to leave based on their belief that their husbands were not going to change. Mary describes this process as "a fatalistic attitude that things will never change."

One of the most unusual reasons for leaving a husband was provided by Gayle. She left because her husband brought another woman to the house. According to Gayle, that was "the straw that broke the camel's back . . . it was the ultimate humiliation." In addition, her husband forced her to take her children and leave the house. Gayle was subjected to severe forms of torture for over 10 years. She was hospitalized on several occasions. Her husband used a knife repeatedly. He cut off three of her fingers, repeatedly threatened her with a gun, and once pulled the gun on her daughter. Additionally, she always had broken fingers, toes, and shoulders. She never sought medical attention for any of these "minor" injuries. Gayle never left or attempted to leave her husband before. She was waiting for the "right time." She explained that she did not walk out before because, although she wanted to leave, "I did not have any doubt in my mind that if I left he would have retaliated, searched for me everywhere, and kicked my head off my shoulders . . . but now he could not say, 'why did you leave?' I can say legitimately that 'I did not leave . . . you told me to leave.'" She chose not to take the risk of losing her life, but the price was high. She lived in total isolation for 10 years. She was not allowed to work, although she had a college degree in nursing. She was not allowed to contact her family of origin, who lived 600 miles away. He took the phone out 6 months after they got married because he was afraid that she would use it. Rather than sending the children to school for

the last two years, he hired a full-time private tutor for his 10-year-old son and 9-year-old daughter. Gayle indicated that she did not know where to go or how to take the bus. After she was put out on the street, she met a policeman who told her about the shelter. Prior to this she had no knowledge of shelters for battered women.

Subjective Evaluation of Shelter Experience

Of the 25 women who managed to stay at the shelter long enough to be interviewed for the second time (3 weeks), 96% reported that they had not been in this shelter before. It was their first and only visit. In addition, the majority of women had not sought prior help from other battered women shelters. Only 25% reported that they experienced being in shelters for battered and/or homeless women. Once they made the decision to seek institutional help several questions arise: "What are their needs?" "How helpful is each service provided by the shelter?" "What is not helpful?" "What suggestions do they have to improve the shelter's operation?" The answers to these questions were obtained from the victims. A broad enough list to include a wide range of individual needs was created. Responses were classified into 19 major categories addressing what was most helpful for each woman. In general, more than one response was offered by each woman indicating the complexity and multiplicity of their desires.

The most frequent response was provided by 65% of the women who shared the common belief that the practical, informative, and moral support they had received from the staff was the most helpful aspect in being at the shelter. Rose described the range of the assistance offered and/or given by the advocates. She stated: "My advocate was

very helpful; she did her job very well. She was available just to talk to whenever I asked her, she went with me to court for the hearing, and she gave me rides when I wanted to look for an apartment." Typical comments included, "The staff is very nice, supportive, and understanding . . . they make you feel at ease . . . they are helpful by being here . . . they are a good sounding board . . . they are wonderful . . . they show you that they have confidence in you . . . they encourage you to make your own decisions . . . and they make you feel like you are a real person."

The second most popular response was provided by 48% of the sample. These women believed that what was most helpful to them at the shelter was interacting and being with other battered women, sharing similar experiences, realizing that they are not the only ones, exchanging information, and learning new survival techniques. These were essential dimensions of their experience at the shelter. In addition, many women reported positive feelings of being understood, accepted, and connected with other women, which were in direct contrast to their long-standing feelings of loneliness and isolation.

The case of Ann illustrates the difference between her present and past states of relating to significant others. It is representative of the conflicts and struggles of many battered women in their primary relationships. Ann describes her sense of existential aloneness as follows: "Beforehand I did not have anybody to talk to. His family thinks he walks on gold . . . to them he does no wrong. My family could not relate to me. They think I should stay with him because I have a comfortable environment. I have a big house, three cars, etc. They say that the children and I belong there. They do not understand that the

material goods are not enough to make me happy . . . just being here at the shelter is not restrictive to try anything. . . . I am making a whole new set of friends here, old friends cannot even see why I want to file for divorce . . . they told me how can I give up all this just for a fight or argument? I do not need these types of friends . . . my new friends at the shelter are happy for me about starting my new life . . . old friends say damn you are starting all over!"

The results also demonstrated that, although the needs of women who seek help from the shelter vary dramatically, what seems to be common to all is their basic need for an alternate residence which can provide safety and a life without violence and fear.

Table 20 shows the salient positive aspects battered women experience at the shelter. The shelter provided different services/activities for different women. Table 16 presents the common, as well as the distinct, needs of women. The general list of needs can be classified into three broad categories: (1) material and physical needs, (2) social and interpersonal needs, and (3) inner and personal needs.

An example of how the first group of needs were met is the "economic and material assistance provided by the shelter." Indicative of the needs met in the second category were these statements: "sense of connectedness with others," "interacting and being with other battered women." The largest number of statements can be viewed as related to women's inner self-development. They are indicative of the women's awareness of significant internal changes in their behavior and perception of self as a result of being at the shelter. Included in this category are the following items in Table 16: items 7, 8, 12, 13, 15, 16, 17, and 18.

TABLE 16
POSITIVE ASPECTS OF SHELTER EXPERIENCE

	What Was Most Helpful	Checked %
1.	Practical and moral support of the staff	64
2.	Interacting and being with other battered women	48
3.	Living in pleasant atmosphere without abuse	36
4.	Immediate place to go to	32
5.	Economic and material assistance	32
6.	Living without fear	28
7.	Setting goals and developing a sense of direction	24
8.	Channeling her time and energy into her own self-development	24
9.	Sense of connectedness with others	20
10.	Sense of being accepted and understood	20
11.	Child care program	16
12.	The freedom to make her own choices	16
13.	Hopeful and positive outlook about the future	16
14.	Privacy	12
15.	Feeling of self-worth	12
16.	Gaining a sense of being in charge of own life	12
17.	Learning to be more expressive and assertive	4
18.	House rules	4
19.	Sense of being independent	2

Women were also asked to specify the three most-needed services. They were asked to choose their responses from a list of 16 services which tended to be provided by most shelters. The results revealed that 85% of the women indicated that emergency housing is the first and most-needed service. The second most-needed service is legal advocacy, which was chosen by 28% of the women. Food was perceived by 20% of the women as the third most important need.

Although the women were able to verbalize the difficulties they encountered at the shelter, their overall assessment of the services and support they received was positive. They seemed very reluctant to express any complaints or dissatisfaction. For instance, almost half of the clients' initial and automatic response to the question about difficulties was: "I cannot think of anything that was not helpful." However, when they did comment negatively about their experience at the shelter, their criticism tended to be soft, colored with overtones of apology and rationalizations. The following statements illustrate this point: "It would have been nice if . . ."; "Don't take me wrong, now, but . . ."; "Maybe sometimes I feel depressed being here because people cannot come and visit you, like my mother and my sisters, but I do understand that these rules are important for the physical safety of every woman here"; "It was rough at first to live with so many women, but I knew that it is temporary so I can grin and bear it . . . I remembered that I do not have to live with the folks the rest of my life."

However, the most frequent complaint was voiced by 28% of the sample who saw the problem of overcrowding as the least helpful part of being at the shelter. Living with many different personalities,

occupying limited space, and not having enough privacy seem to produce some stress. In addition, women complained of some difficulty in adjusting to a shared living in a collective group house, being in a non-familiar environment, and missing their own material conveniences (for more details consult Table 17).

Quite a few women expressed some difficulty in dealing with their children while staying at the shelter. They felt that their children became out of control, spoiled, and were acting "strange." They do not know how to discipline them any more.

Barbara: "The kids here are acting very differently and I don't understand why. They have changed. They are always tossing. . . My daughter is having a hard time getting to sleep. My son ignores me every time I talk to him. He never did that before. They lost their manners and courtesy."

Rita: "Initially, living with so many families was very terrible and traumatic for the children. Moving to a place that was not familiar. They would not go to sleep at night. They were very afraid of what might happen. They cried a lot, etc. . . . It is better now . . . their personalities have changed. Daughter became dependent and clinging; son became outgoing and independent. Each one of them was exactly the opposite before."

Rita: "I am having a hard time disciplining my children . . . they got really spoiled . . . they don't listen to me any more. . . . Although I am happy to leave, I am going to miss the child care. . . . My kids are going to miss it; they already ask about Marta."[1]

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[1]Marta is one of the staff at the shelter.

TABLE 17
NEGATIVE ASPECTS OF EXPERIENCE AT THE SHELTER

	What Was Not Helpful	Checked %
1.	Nothing that I can think of	48
2.	Overcrowded	28
3.	Living in non-familiar environment and missing their own material goods	24
4.	Difficulty in disciplining the children	16
5.	House rules	16
6.	Shared living in a collective group house	12
7.	Limited time of stay	8
8.	Limited financial assistance	8
9.	Feeling of being used by other women	8
10.	Shelter is short staffed	4
11.	Limited day care facilities	4
12.	Seeing people take advantage of a give-away program	4
13.	Advocates did not give enough detailed information	4
14.	Proximity of shelter to old address	4
15.	Asking others for favors	5

Some of the women hinted that the source of their discomfort with their children stems from following the rule of "No violence of any kind is permitted in the shelter." Women are told directly by the staff that they cannot use physical force and/or the threat of it to discipline their children. No spanking, slapping, pinching, fights, threats, screaming, etc., are tolerated. Some women are not accustomed to using non-violent methods of discipline. They have not learned alternative ways of relating to their children's inappropriate behavior. As one of the women stated: "I was raised by my grandmother who believed in spare the rod and spoil the child. . . . Kids tend to get looser and looser and looser without physical punishment."

It was also observed that some of the factors viewed as helpful by certain women were condemned by others. In other cases, the same women counted the positive and negative qualities of the same dimension. For example, Laura believed that the house rules were very helpful to her. She felt that they provided her with some external structure that she needed. She specified that it was good for her to do certain things at certain times. Having to be at the shelter by 10:00 P.M. helped her to get up early and go to work every day. Similarly, Rosey felt that the house rule concerning confidentiality was very helpful to her. She liked the idea that no one knew where she was and that no one could get in touch with her unless she contacted them. She felt safe and that was what she most needed at that time. In contrast, some women viewed house rules as a hindrance to their personal freedom. They perceived the rules as a contributing factor for furthering their feelings of isolation and disconnectedness with others and the external world.

In addition to identifying common responses, one example of a unique reaction is presented. Jan stated that "what disturbed me was seeing individuals not taking the initiative to use this temporary time at the shelter as a stepping stone to making their way successful . . . to see people being content in being on welfare . . . that bothers me very much . . . seeing a 22-year-old person with very limited reading and writing skills, but who is not taking any action to improve her plight in life . . . that is really disturbing to me . . . another thing that disturbed me was seeing people taking advantage of a give-away program . . . abused people begin to feel that they are supposed to receive freely, too often they don't view it as something to be thankful for."

Another rare response was given by a client who thought that the only drawback she had experienced was the location of the shelter. The shelter was located in the same neighborhood as her old address. She was afraid that her husband might discover where she was staying. She reported being terrified of his possible retaliation.

Clients' Recommendations

When asked what recommendations they would make, most of the women initially stated that there was nothing that they needed which was not provided by the shelter. Results revealed that slightly over half of the women stated that they could not think of any suggestions to improve shelter operation. However, later in the interview some of the women did make some recommendations. Their final responses were categorized into eight broad areas of suggestions as shown in Table 18.

TABLE 18
CLIENT'S RECOMMENDATIONS

Suggestions	Checked %
1. Cannot think of anything	52
2. Provide professional counseling/personal and vocational	16
3. Hire more staff	16
4. Improve child facility	12
5. Provide transportation	12
6. Improve house management	12
7. Improve security measures of shelter	8
8. Improve physical conditions of the house	8

Their feedback tended to reflect the general need for improving the physical and psychological conditions of the house and its services. The most frequently given suggestions were as follows:

1. Provide professional counseling which would include both vocational and emotional counseling. Group therapy for battered women at the shelter also was suggested. One client stated, "We need a therapist or social worker within the shelter. You can bring therapists from the outside and run the group here, because it would be very hard to go to another big group and share your problems with total strangers . . . in here we share everything that has to do with opening up to each other . . . group counseling will work well here . . . we have group house meetings, but that is different."

2. Hire more staff. Many women felt that though the house is full of clients, it is inadequately staffed. The staff was very busy, and they had to take care of many different things. Several women suggested that a professional cook should be hired as opposed to rotating this chore among the clients. They felt that less food would be wasted if only one person was responsible for the cooking.

The child care program was another source of complaint. Twelve percent of the women suggested that it would improve the facility if more reliable volunteers were trained to work with the children or by having a continuous 9-5 day care, especially for working mothers.

One of the women stated that she would have felt much safer if her son stayed at the shelter while she was at work instead of taking him to a babysitter. Similarly, Karen was preoccupied with one thought. She kept repeating the same statement over and over throughout the

interview, "I have got to get that money." She needed bus fare of $155 in order to take her 3-year-old son to stay with his grandmother. It was clear to her that she could not afford child care, and she believed that her mother was her only viable alternative. She summarized her struggle by saying, "If they only knew how poorly working mothers are paid."

CHAPTER V
DISCUSSION

Methodological Limitations

There are several drawbacks in the design of the present study which need to be taken into account when discussing the results and their implications. First, all the women in the sample were volunteers who were comfortable sharing their battering experience with the researcher. Most important of all is the fact that they have taken a major step to leave the abusive situation, were ready to reassess their past experience, and were willing to explore alternatives and make some changes in their current lives. Therefore, one may speculate that this group of battered women is likely to be different from battered women who are still living with their abusive mates. Second, the relatively small sample size raises the question as to whether the relationships between the dependent and independent variables were, in fact, true associations or occurred because of random factors. Third, it would have been preferable for the control group women to match with the abused women group on all the background variables. A more appropriate sample would include data from battered and non-battered women who were alike in terms of their average age, income level, educational attainment, marital status, employment status, racial composition, etc. The similarity of control and experimental groups in all variables except the experimental ones will insure that the observed differences and/or changes will be attributed to the independent variables rather than to

initial demographic differences between the two groups. An even better design to test the impact of battering and sheltering on the emotional functioning of the victims would contain data from battered women who come to the shelter and from battered women who are still living with their abusive partners. However, due to sampling difficulties which have to do with the nature of this clinical study, it was impossible to obtain the desired samples. Therefore, it should be stressed that the study is exploratory in nature and that the findings are specific to this particular sample. Thus, results cannot be generalized to all women battered by their husbands, not even to all battered women in shelter settings.

During the planning and data collection phase, the researcher decided to gather as much information as possible from the women's health clinic. Those questionnaires that did not match with the battered women's group on particular background variables were to be excluded. However, as the study progressed, it became evident that it was impossible to follow the original plan because of the limited number of respondents from the women's health clinic who volunteered to participate in this study. In order to ensure that the scientific integrity of the study would not be compromised, the procedures for analyzing the data were expanded. A statistical analysis of covariance was conducted to control for any initial differences in the demographic variables that might affect the dependent variables. The results confirmed that the background variables had no significant impact on the dependent variables. The findings also revealed that the variable of battering was the main discriminating factor between the two groups. Additional norms

which were derived from other major studies in the field were also used as a basis for comparison. It was hypothesized that by comparing the results of the current study to normative data, a more comprehensive profile of the battered women would be obtained. Therefore, it is more appropriate to call the control group a normal comparison group rather than a matched control group. If the study is replicated, the researcher hopes to have access to a larger and more varied population; this might guarantee the possibility of a matched control group.

Regardless of the restrictions on generalizability imposed by purposive samples, their contribution to our understanding of wife abuse should not be ignored. As Pagelow (1981) says, "Each case study may contribute additional insight into the problem. The additive effect of many select samples may be the best means to knowledge-building, provided limitations applicable to each are kept in mind when drawing conclusions" (p. 237).

Demographic Background Variables

Race

The sample of the current study seems to be biased toward over-representation of black and other minority women in the battered women group. This finding can be misleading. One should not prematurely infer that wife abuse is more prevalent among ethnic and racial minorities for several reasons. First, many Caucasian women are excluded from the shelter population because they tend to have alternative resources which enable them to avoid going to a shelter. Second, the shelters that the sample of battered women were drawn from are located in predominantly black areas. Finally, it should be kept in mind that the racial

composition of the battered women group is almost proportionately representative for the region where the study was conducted. Blacks in this geographical location account for 80% of the total population.

Previous research findings on the racial composition of the samples studied reveal an ambiguous picture. Some studies show that the racial/ethnic composition of their samples tend to be proportionately representative of the racial distribution of the population where the studies were conducted (Carlson, 1977; Star, 1978). Other studies assert that wife abuse is highest among blacks (Stark & McEvoy, 1970; Straus et al., 1981).

Straus et al. (1981) propose that the stress, discrimination, and frustration that minorities encounter and the fact that minorities are still disenfranchised from many advantages which majority group members enjoy can lead to higher rates of violence toward women. They argue that minority men use violence against their partners to compensate for the state of powerlessness they experience in society at large. It seems as if the home functions as the only domain where they can assert their power and dominance and live up to the culturally prescribed macho image of man which encourages the use of physical aggression.

Education

The educational attainment of battered women in this study seems to be consistent with the findings of Carlson (1977) and Hofeller (1982) with the tendency to have fewer women at the lowest level (grade school) and at the highest level of education (graduate school). In addition, it was necessary to compare the results of the present sample with

Pagelow's (1981) findings, which were derived from a large sample of 347 battered women in shelter settings.

Pagelow closely examined the similarity and discrepancy between the educational attainment of battered women in her survey sample and national statistics on the educational level of wives in the U.S.A. The education of women in Pagelow's sample, in the current study, and national statistics is presented in Table 19.

The comparison reveals that battered women in both samples are not as undereducated as women in the national sample at the lowest category--grade school. It is also noted that, in contrast to national sample women, battered women tend to be dropouts from high school and college at a higher rate. Fewer women in the current sample graduated from high school. At the upper levels of education, battered women in this sample differ from the other two samples in that fewer women graduated from college, yet a higher rate graduated from graduate school.

The findings of this study are consistent with Straus et al.'s (1980) survey results which challenge the common view that family violence does occur predominantly among the least educated families. On the contrary, results of the present study revealed that grade-school-educated women were the least likely to be abused by their partners. Women who have not completed college are the most likely to be physically abused.

Straus et al. (1980) suggest an explanation for the complex relationship between education and violence in terms of a person's relative, rather than absolute, educational attainment. They argue that it is more stressful to an individual to have a moderate education than

TABLE 19
EDUCATION OF CURRENT SAMPLE WOMEN COMPARED WITH PAGELOW'S SAMPLE AND NATIONAL STATISTICS

Response Category	Sample Women %	Pagelow's Sample %	National Women %
Grade school	2.5	5.2	13.0
High school attended	17.5	25.4	16.0
High school graduate	25.0	34.6	45.0
Post secondary	15.0	n.a.	n.a.
College attended	27.5	26.2	14.0
College graduate	2.5	6.3	8.0
Some graduate school	2.5	n.a.	n.a.
Graduate school/advanced degree	7.5	2.3	4.0

to have little education. People with average education, high school diplomas, may feel cut off from the high status, well-paying professional jobs. Therefore, the educated worker may experience more stress and frustration than the uneducated worker. This proposition may explain why the highest percentage of victims is among those who attended college but were not able to complete their studies. It would be interesting to study the relationship between dropout and violence. In the current study there is no available information regarding the factors which contributed to making the decision to drop out of college or high school. It is also not clear whether they dropped out before or after they were involved with their abusive partners.

Income

Results of this study do not support the Straus et al. (1980) finding regarding the relationship between violence and family income. They found that families living at or below the poverty line (under $5,999) had a rate of violence between husbands and wives which was 500% greater than the rate of spousal violence in the most well-to-do families (incomes over $20,000). In contrast to the Straus et al. results, it was found that the most violent group in this study were those families which earned over $15,000 per year. Violence was much less likely to occur among poor families. However, when the earning power of the victims is focused on, our results revealed that violence was equally frequent at the lower and upper levels of the continuum.

One may conclude that in this study income does not seem to play a significant role in identifying victims of violence. Our results challenge the conventional thinking that violence is confined to poor

families. Battered women in this study were distributed among the various income brackets. Some earned wages that were below the poverty line, and other earned more than $20,000 per year.

Marital Status

The results of this study are consistent with Pagelow's (1981) and Carlson's (1977) findings, which indicate that the majority of battered women in their samples were married to their assailants. However, although Pagelow found that the rate of cohabitees in her sample was much higher than the rate in the national statistics, the percentage of cohabiting couples in the current study was almost three times greater than the rate in Pagelow's research. It is possible that these results reflect the growing trend toward couples choosing to live together without legal marriage.

Giles-Sims (1983) also noted that the number of cohabitees in her sample of battered women was unusually high. That is, slightly over one-fourth of her sample had cohabiting relationships. In fact, the data from a national sample of 2,143 adults do not support the hypothesis that there is a higher level of violence in marriage than in cohabiting relationships. It was found that cohabiting couples had violence rates as much as twice as high as did married couples (Yllo & Straus, 1980).

These results suggest that cohabiting relationships per se have not increased the equality and/or quality of the interpersonal relationship between the pair. On the surface, cohabiting might be construed as a liberal and egalitarian form of relating; yet the underlying dynamics and outcomes seem to be similar to those of a traditional marriage.

In this context, Pagelow's (1981) remarks are pertinent. The relatively high rate of cohabitees led her to question the often-quoted statement of the marriage license being a hitting license (Straus, 1976). She argues that the process of shared living arrangements, rather than marriage per se, is the more important factor contributing to violence between couples. Results of this study lend additional support to Pagelow's speculation.

It is also possible that the notable rate of cohabitees might be a reflection on the slightly better position of unmarried women and the relative ease in leaving the abuser and seeking professional help. Cohabiting women might be in advantageous positions when it comes to making the decision to leave. After all, they do not have to deal with the legal and bureaucratic procedures of divorce nor with the familial and societal pressures to keep the relationship intact.

Patterns of Violence

The most obvious finding of this study is the reconfirmation of the fact that battering episodes tend to escalate and intensify with time. This result was documented by several researchers who found that if abuse happens once, it is likely to happen often (Bard & Zacker, 1974; Couch, 1983; Gelles, 1974; Hofeller, 1982; Rounsaville & Weissman, 1977-78). Similar to other research results, this study also found that severity of abuse tends to progress up to the point which endangers the very physical existence of the victim (Carlson, 1977; Flynn, 1977). It was demonstrated that domestic fights go beyond a slap or a shove; serious injuries and use of weapons are likely to occur in assailant-victim relationships. A concrete example of this was provided by Kathy, who

stated that "Now I feel like I was born again, I feel that after the last beating I was very lucky to stay alive . . . I just want to exist, I want to be, I don't want to be controlled any more." Therefore, there is a consensus that any act of physical attack should be taken seriously. The intensity and the impact of these "minor incidents" should not be minmized since many severe cases of battering begin with a slap or a shove (Hofeller, 1983). Therefore, women are encouraged to take immediate action after the occurrence of the first physical assault.

It is believed that playing the role of the martyr may lead the assailant to believe that his victim's silence is a sign of her unspoken approval of violent interaction. Her passive response may reinforce the implicit cultural norm of patriarchal society which legitimizes the use of physical force within the family as a conflict resolution tactic. Ignoring and/or denying her violent reality may also increase the chances of her being hit time and again. Davidson (1978) describes the dynamics and consequences of the victim's inaction. She stated,

> . . . Her husband is learning, whether consciously or not, that hitting his wife was somehow acceptable the last time; she did nothing about it. Thus a pattern is set. All the evidence is that when the first or second assault is not firmly dealt with, there will be more. And the assaults will become more frequent and more severe. (p. 51)

The first incident of physical aggression seems to play a significant role in shaping the future course of the relationship. It is a crucial event due to its power to "break the ice." Once the system of inhibitions has been collapsed, repeated violent acts are more likely to occur. Straus (1977-78) delineates three major reasons which indicate the special importance of even a single beating. They are as follows: (1) even one such event is intrinsically a debasement of human life,

(2) it is physically dangerous, (3) beatings tend to be part of a family power struggle. It often takes only one such event to fix the balance of power in a family for many years. Straus (1977-78) presents a brief segment of an interview to illustrate this third issue. The husband gives the reason for hitting his wife during an argument: "She more or less tried to run me and I said no, and she got hysterical and said, 'I could kill you' And I got rather angry and slapped her in the face three or four times and I said, 'Don't you ever say that to me again!' And we haven't had any problem since" (p. 446).

Hofeller (1982) adopted the theory of disinhibition of anti- and pro-social behaviors, suggested by Benton and Wichman, to explain the escalation of aggression over time observed in laboratory settings. Their theoretical proposition seems to be applicable to research findings in the sphere of domestic violence. Stated differently, this theory appropriately accounts for the observed increase in frequency and intensity of violence over time not only in laboratory experiments, but also in field studies of wife battering. Hofeller's presentation of the theory is as follows:

> . . . It is assumed that in almost any given situation norms exist for both the inhibition and expression of the behavior. A person's decision to act will depend upon the number and relative importance of these competing norms. However, once the behavior has been performed, norms which sanction its display become more salient, while any inhibitory norms become less cogent. This, in turn, reduces the conflict, making further occurrences of the act even more likely. In the case of aggression, disinhibition may also be facilitated by the fact that the reduction in blood pressure and arousal which follows an outburst is assumed to be positively reinforcing: the two interacting processes--ever-increasing inherent pleasure in the aggressive response and the reduced inhibitions accompanying the response--result in escalation. (p. 128)

Although the results of this study were consistent with earlier research findings on the general issue of escalation of both frequency and severity of abuse over time, a more specific question presents itself: Are women in this particular sample more frequently and intensely exposed to spouse abuse than women in other samples? It is somewhat difficult to compare the levels of severity and frequency of abuse in this sample with findings from other studies on these same variables. This difficulty stems from the fact that there are no unified measures for the assessment of frequency and severity. Different researchers employed different scales to elicit this information. For example, while Rounsaville and Weissman (1977-78) presented the severity of abuse in terms of the specific injuries observed in the emergency room (i.e., contusion, soft tissue injury, laceration, serious head injury, etc.), Gelles (1976) constructed a 10-point scale of violence severity which focused primarily on the assailant's violent behaviors (0 = no violence, 1 = pushed or shoved, . . . 8 = stabbed, 9 = shot).

It was noted that the use of weapons as a criterion for a high severity level was cited in most of the studies that dealt with patterns of domestic violence. The proportion of women in the current sample who reported that their partners had threatened them with a knife or gun, 45%, was lower than that in Pagelow's (1981) study, 57%, but far higher than the percentage in Hofeller's (1982) research, 14%. Similarly, the number of women who were shot or knifed in this study, 22.5%, is very close to Pagelow's findings, 25%, but much higher than Hofeller's results (8 percent of those who were threatened were actually shot). Other research findings with regard to the use of weapons are not very accurate or specific. For instance, although Flynn (1977) reported that

many women in her study felt that their lives were in danger due to the presence of weapons, she did not specify the exact number of women who were threatened, shot, knifed, or hit with a hard object. Similarly, Carlson's (1977) report of her findings on the issue of weapons is also somewhat ambiguous. She stated that weapons were "involved" in 50% of the cases in her sample. It is not clear whether weapons were actually used on the women or they were only threatened by them. However, she mentioned that 60% of the weapons were household objects, 25% were guns, and 16% were knives.

One possible explanation of the relatively higher proportion of women who were threatened by a weapon, shot, or stabbed, in both Pagelow's study and the present study, is the source from which the samples of these two studies were obtained. These results may have an indirect bearing on the extent of abuse particularly experienced by battered women who went to the shelter. Thus, one may speculate that shelters may represent the last resort available to women who reached the saturation point of violence, who were unable or unwilling to tolerate further abuse, and who were seriously considering terminating the abusive relationship and starting new lives. For these women, abuse had become so severe that they were compelled to flee from the danger zone; it became evident to them that it was a choice between life and death. These results lend support to Gelles's (1976) hypothesis that the severity and frequency of abuse influence the actions of abused wives such that the more severe and more frequent the violence, the more likely the wife is to seek outside assistance.

Another alternative explanation to the higher rates of severity and frequency of violence among women in shelters may be attributed to the general non-judgmental shelter atmosphere which encourages women to self-disclose openly and honestly without worrying about being blamed or condemned for their own victimization. In addition, the shelter provides her with the opportunity to be alone, to focus her energy and time on herself, to step back and re-evaluate the destructive nature of her previous experience, and to sort out her plans for the future. This introspective process may lead her to realize, acknowledge, and freely verbalize the real magnitude of the danger in living with the abuser. This new attitude is in contrast to what she had been accustomed to doing in the past, i.e., her tendency to minimize the severity and impact of violence as a protective coping strategy for dealing with the painful situation. This new insight may also function as a further justification for her decision to leave the abuser and may resolve some of her conflicting feelings about making the relationship survive.

Generally speaking, it was observed during the interview that it was somewhat difficult for many battered women to be specific in pinpointing the frequency, duration, and severity of abusive events. It seems as if they had never thought about abuse in categorically quantified measures. The question "How many times have you been attacked" appeared to be abstract and required a lot of thinking and concentration to be answered. Battered women in this study tended to be readily able to describe specific violent events in detail and at great length, but it was hard for them to count them.

Probably, compartmentalizing the abusive situation into small and isolated units rather than summing them up to form a gestalt has a protective and self-preserving element for the battered women. Looking at each abusive event separately may minimize the degree of rage, pain, degradation, humiliation, and demoralization she is likely to experience as a result of repeated abuse. Also, becoming numb and resigned protects the women from taking any steps to alter their abusive reality. It is also possible that while they were interviewed, they were trying to avoid re-experiencing the pain of the actual beating that may result from a flashback of past memories. The point of underestimation of the seriousness of abuse is illustrated in the following excerpt from an interview with one of the women who was shot by her partner and was permanently damaged: "I cannot remember being physically hurt by him hitting me; he has big hands, if he did hurt me I will be broken because I am small." This same woman indicated later on that she experienced injury necessitating hospitalization as a result of his violent attacks.

The Power to Leave

In order to understand the factors which influence the decision to leave the abusive partner, one should also address the variables which contributed to keeping the battered woman captive in her own home. After reviewing the current literature and conducting in-depth interviews with battered women, it becomes apparent that the forces involved in making the decision to stay or to leave the abusive situation are very intricate.

The researcher hopes that the following presentation of the two sides of the coin might crystallize the complexity of the violent action and reaction. It might provide a better sense of the contradictory forces operating in making the final choice of either surrendering to the partner's seemingly superior power and staying in the destructive relationship or gathering all the resources and taking the necessary steps toward starting anew. It was also evident that "Why did she stay?" was one of the most frequently asked questions by both laypersons and professionals in the social sciences. However, the issue of what prompts the woman to leave the abuser, especially after enduring many years of violence, was rarely addressed.

Snell et al. (1964) were the first to raise and provide an answer to the question of why women in their sample had chosen that particular time to appeal for help outside their families, considering that their marriages were marked by long-standing history of frequent physical abuse. They found that the wives' first answer to this question almost always involved the children in some way. Their further exploration revealed that the involvement of the eldest male children in the last violent episode had triggered the mothers' court appearances. Typical reasons given by these wives for their action emphasized the male child's increasing age and strength: "He is growing old enough now for his father's behavior to affect him," or "He is big enough now to really hurt his father" (p. 109).

Similarly, several women in the current study indicated that they left their husbands either because they started to notice the impact of abuse on their children or because of their partners'

expansion of violence and/or threats of violence toward the children. More specifically, some women reported that they did not want their children to grow up believing that it is normal for a man to beat up his wife and that it is okay for a woman to be beaten. However, in contrast to the Snell et al. report, the welfare of the children was not the primary and/or only reason reported to trigger women's initiative to leave the abusive partner.

The findings of this study lend some support to Goodstein and Page's (1981) suggestion that the decision of the wife to call for help can be seen as related to a significant change in her behavior, not necessarily connected with the husband's assault per se. However, a closer examination of the current study's findings of the 17 reasons for leaving abusive partners gave rise to a safer speculation. One may speculate that the interplay between internal and external processes might be viewed as an additional level of analysis of the significant factors which determine the timing of seeking institutional help. The decision to leave might be an outcome of inner changes in women's perceptions, attitudes, and feelings about self as well as the result of the different dimensions of the abusive behavior in and of itself. For instance, while the reported reason of "escalation of verbal and emotional abuse" can be viewed as an external motive for women's action, some women's new realization that their "attitude shifted from saving the family toward rescuing self" might be indicative of internal changes which are responsible for mobilizing women toward terminating the violent relationship.

Moore (1979) summarizes the different conditions which facilitate and strengthen women's need to leave. They are as follows:

1. Attributing the beatings to some characteristic of their husband rather than blaming themselves.

2. Believing that the beatings are going to continue rather than expecting a change in the husband's behavior.

3. Having a support system of friends, family, women's groups, shelters, churches, or any other person(s) who let them know that they are okay and need not take such abuse.

4. Leaving is more likely when the battering becomes more violent and frequent.

5. Leaving is more likely when they do not have children. If they do have children, they are more apt to leave when the partners start to beat the children.

It is not clear from Moore's presentation how much power each and every variable has in assisting the women to determine the timing of leaving the abuser. One may suggest that a combination of events operate in making the final decision to leave. Also, certain factors might be more crucial than others to some women, and these same factors might be marginal to other groups of women.

Gelles (1976) identified three major factors that distinguished wives who sought help form those who did not. The list of factors provided by Gelles seems to be limited in comparison to Moore's. Gelles primarily focuses on the external and sociological variables that lead the battered women to leave the violent home. There is no mention of any psychological components which facilitate the process of terminating the abusive relationship. The three factors are as follows:

1. The more severe and the more frequent the violence, the more likely that women will seek outside intervention.

2. Exposure to conjugal violence in family of origin makes some women less tolerant of family violence and more desirous of ending a violent marriage.

3. The fewer alternatives the wife has to her marriage, the more entrapped she is in the marriage, and the more reluctant she is to seek outside intervention. Women's economic independence (measured by holding a job) was the best predictor of making a decision to leave the partner.

Rounsaville and Weissman's (1977-78) research findings on the issue of leaving the abusive partner seem to be more comprehensive and, at times, contradictory to Gelles's results. Unlike Gelles, they seem to emphasize the intrapsychic processes involved in making the decision to leave without ignoring interpersonal factors and the husband's violence per se. In fact, they suggested that women's decisions to leave may be based on a subjective assessment of the pain of staying and the risk of leaving rather than the actual availability of resources. They arrived at this conclusion based on their finding which revealed that age, social class, marital status, psychiatric history, employment status, and number of children did not distinguish those who left from those who stayed. However, they were able to identify six factors which correlated significantly with leaving the abuser: (1) severity of abuse; (2) type of abuse; (3) fear of being killed; (4) having called the police; (5) the partner's having beaten the children; and (6) intervention by others outside of the dyad, especially medical personnel.

The responses of the women in the current study appear to combine some aspects of Moore's, Gelles's, and Rounsaville and Weissman's speculations, with a tendency to stress the personal and intrapsychic dynamics operating in making the decision to leave. The partners' violent behavior seemed to play a secondary role in finalizing their decision to sever the relationship. Even when they reported that the abuse was a primary motivating force behind their decision to terminate, they emphasized that it is their new outlook toward violence rather than violence per se which affected their decision to leave. For instance, several women indicated that they decided to leave when they suddenly realized that the abuse was arbitrary and abrupt as opposed to their former belief that it was their fault that their partners beat them.

Although women in this study were not asked why they stayed with partners as long as they did, a brief presentation of what was found in the literature may provide a holistic perspective on this controversial subject. Morgan (1982) suggested three theoretical levels of analysis, which operate simultaneously, to answer why battered women remain in violent relationships: (1) political, (2) cultural, and (3) psychological. Other researchers' suggestions might be incorporated into any one of these broad explanatory categories. They may use different labels and provide additional details to describe the reasons which compel women to remain in abusive relationships.

Political Perspective

From the political vantage point of view, it is believed that women's economic dependency empowers her husband and perpetuates his position of dominance in the family. It has been indicated that

battered women tend to have limited job skills and experience; if employed, their wages are not sufficient for basic survival needs of food and shelter. In addition, the lack of community resources available for the battered women is evident. Even if shelters exist, they tend to operate at full capacity; and many women are denied safe houses simply because there is no room for them and their children. Carlson (1977) noted that if the necessary services for battered women are not provided immediately, they are of little use to the victims. Finally, the police, legal organizations, and the judicial system in general proved to be ineffective in dealing with marital violence (Freize, 1976; Gelles, 1976; Hofeller, 1982; Morgan, 1982).

Cultural Barriers

Battered women encounter enormous pressures from family members and close friends when they discuss their decision to leave abusers. Often they are encouraged to remain married and keep the family intact. Women are perceived as solely responsible for preserving the family institution at all costs even when their lives are at stake. They are told they must "stick it out for the sake of the kids," "you have made your bed so lie in it," "marriage is the woman's responsibility," and "if they were really good mothers, they wouldn't deny their children a father" (Morgan, 1982, p. 14).

Wetzel and Ross (1983) noted that religoius values play a significant role in holding couples together. The marriage vow "Til death do us part," taken in front of significant others, becomes a rigidly

internalized belief which hinders women's actions toward building new lives.

Moore (1979) pointed out that social stigma is another inhibiting factor in a woman's decision about leaving. She indicated three types of situations which described the social stigma experienced by battered women: (1) embarrassment to admit that their marriages have been bad, (2) embarrassment that either they or others will hold them responsible for their own victimization and that they deserve the beatings, and (3) embarrassment that they have stayed in such a violent relationship for so long.

Psychological Factors

Several researchers have indicated that fear is one of the most paralyzing factors in keeping victims imprisoned in their own violent homes (Hilberman & Munson, 1977-78; Hofeller, 1982; Moore, 1979; Wetzel & Ross, 1983).

At first glance, it might seem contradictory that fear entraps women in violent homes. Since death is a possible outcome of staying, one may expect women to escape the dangerous situation. However, many women are afraid of death if they either leave or stay with their abusers. It is quite common for a man to threaten that he will come after his wife and kill her or other family members should she try to leave. These threats go as far as hiring a private detective to find and kill the victim in case she decided to leave. Many women reported that they had not experienced a real sense of relief even after separation or divorce. They were still terrorized of their partners' retaliation and coercion. They experienced an added harassment which was

characterized by excessive phone calls, apologies, and promises to change. ("I will never do it again," was a typical response of the abuser.) Another fear they have is the fear of the unknown. She is afraid to leave and experience "the loneliness, financial devastation, failure, possible loss of friends and family . . . it is a very drastic and lonely move for her to consider. After all, if the one who loves you treats you like that, what might the rest of the world do to you" (Moore, 1979, p. 22).

Star et al. (1979) argue that the personality makeup of the women and their ambivalence toward their husbands affects their decision to terminate permanently the violent relationship. Women's perceptions of self as reserved, not quick to initiate action, good, generous, and wanting to help and care for others may cloud their decisions to leave. They also internalized society's expectation of women as being nurturing, loving, and forgiving. They stay because they believe that they should support, rather than abandon, their partners who desperately need their help (Hofeller, 1982). Also, their views of their partners as men with problems and deserving of sympathy held them from taking action to end the relationships. Many women stay because they feel sorry for their husbands.

The positive strokes a woman receives in between the battering episodes function as an intermittent reinforcement which strengthens the bonds between the victim and the abuser and makes it more difficult for her to leave (Wetzel & Ross, 1983).

Hofeller (1982) believes that the emotional abuse a battered woman is subjected to affects her decision to leave. She argues that,

as a result of the psychological beatings, the woman herself comes to believe what her husband had frequently told her: that she is incompetent, worthless, stupid, and incapable of surviving on her own. She comes to accept that she does not deserve any better.

Learned helplessness, anxiety, shock, guilt, shame, hopelessness, humiliation, and an overall resulting low level of self-esteem are other psychological components which serve to maintain the status quo in the violent home. These emotional states keep battered women immobilized both physically and psychologically (Moore, 1979). In conclusion, the decision to leave the violent partner is obviously a complex one. Whatever the reasons might be, most victims progress through different stages and experience a number of separations before they make the final break.

Depression and Anxiety among Battered Women: Pre- and Posttesting

The first hypothesis of this study predicted that there would be initial differences between the battered and non-battered women in depression and anxiety. The first hypothesis stated that battered women would show higher intensity levels of depression and anxiety. The results were in the predicted direction. The data revealed that a substantial number of women in abusive relationships manifest symptoms of clinical depression and show high levels of both trait and state anxiety. The results confirmed the initial speculation that battered women constitute a high-risk population for depression and anxiety. These findings confirm the results of many previous studies as well as

the clinical observations of those who worked closely with battered women (Douglas, 1982; Gellen et al., 1984; Goodstein & Page, 1981; Hilberman & Munson, 1977-78; Rounsaville & Weissman, 1977-78).

Do these results imply that there is a causal relationship between battering and affective disorders? Can we make the inference that battering precedes the onset of depression and/or anxiety? How can these results be integrated with our current theoretical knowledge on the causes of depression/anxiety? An attempt to answer these questions will be presented shortly.

As far as the first question is concerned, regarding the nature of the relationship between battering and emotional disorders, it should be kept in mind that one problem inherent in the study of wife abuse is the difficulty of differentiating those characteristics which are present in the women prior to abuse and those which are a consequence of the abuse itself. Specifically speaking, the question is whether anxiety- and/or depression-prone women end up being in battering relationships, or whether the battering in and of itself causes them to experience depression and/or anxiety. One way of dealing with this problem is to obtain pre-abuse data and then compare past and current status of the abused wife. Since it is extremely difficult to obtain this information, a control group was used in this study as an alternative procedure to tackle this issue. However, regardless of the nature of the relationship between battering and emotional dysfunctioning, empirical evidence consistently indicates that a sizable proportion of battered women suffered form clinical depression and anxiety.

The results of this study may contribute to our understanding of the complex relationship between battering and emotional states. They may aid in reconceptualizing the meaning and the function of the intrapsychic dynamics which were used to describe the personality profile of the battered woman. Traditionally, the battered woman had been accused of possessing a particular personality profile which contributed to her own victimization. Passivity, dependency, masochism, and low self-esteem were some of the frequently ascribed labels to characterize victims of violence, who were then blamed for eliciting the abuse.

Rather than condemning the battered woman and holding her responsible for the abuse, one may regard dependency, passivity, masochism, and the negative view of self as components and symptoms of the depressive state rather than as personality traits of the abused woman. For instance, one may argue that battered women do not stay in violent relationships because they enjoy the abuse or because they are emotionally dependent on their spouses, but rather, their depression depletes the psychological energy required for actively changing the abusive situation. Also, the difficulty in depicting an accurate profile which distinguishes those who are battered from those who are not stems from the observation that virtually any woman can be the victim of domestic violence at one point or another. It was noted that even when profiles are suggested, some authors tend to be guarded in their descriptions. They tend to portray the profile in a relative, rather than in an absolute, manner (Hofeller, 1983; Wetzel & Ross, 1983). In fact, very few researchers have questioned the validity of common arguments regarding the personality profile of the battered women. Wetzel and Ross (1983)

and Follingstad (1980) suggested a counter argument which refuted the ideology of "blaming the victim" and lend support to our interpretation of the current results. They believe that the profile of the battered woman is a result of the unhealthy milieu in which she has been living. They argue that the victim's style of responding has been shaped into a passive, dependent, helpless, and passive-aggressive as a consequence of living in an abusive situation over a prolonged period rather than as an antecedent of it.

The great extent of depression and anxiety among battered women may also be conceptualized in terms of their adaptive functions to the battering situation. Submission and passivity, direct products of depression, can be viewed as survival mechanisms which aim to protect the battered woman from further brutality. This view is supported by Follingstad's (1980) remark on the helplessness of battered women. She wrote: ". . . the frequent complaint that change attempts result in increased abuse supports the view that battered women would find a passive style a sensible one and frequently their only perceived alternative" (p. 295).

Similalry, anxiety can also be viewed as an adaptive coping response to the violent situation. The high levels of anxiety among battered women support the notion that anxiety has a useful function. Many writers believe that anxiety serves as a signal of danger which prepares and mobilizes the individual psychologically and physically for responding to a threat (Beck, 1976).

Freud's (1966) description of realistic anxiety appears to be a plausible theoretical explanation for the type of anxiety experienced by battered women. He wrote:

> Realistic anxiety strikes us as something very rational and intelligible. We may say of it that it is a reaction to the perception of an external danger--that is, of an injury which is expected and foreseen. It is connected with the flight reflex and it may be regarded as a manifestation of the self-preserving instinct. (pp. 393-394)

It should be emphasized that in the case of battered women, anxiety functions as a realistic alarm for the possibility of further emotional and physical hurt. It maintains and enhances the mere survival of the victims. The battered women's anxiety can hardly be described as "pure" or "free-floating" anxiety since it has a solid base in these women's reality. Thus, battered women's anxieties tend to be intrinsically connected with danger. Battered women in this study had been subjected to repeated, frequent, and severe traumatic episodes. Repeatedly, they had been verbally and physically threatened with loss of their lives or their children. They were terrified because they know the almost unlimited range of violent behaviors of which their mates are capable. Some of them objectively assessed the danger of staying with their partners. They anticipated the dreaded event of lethal encounter. As many of them reported, it was this new evaluation of eminent threat to their lives that finally motivated them to seek professional help and to take an active role in changing their abusive relationships. Therefore, it is not surprising that living under such circumstances would produce high levels of both state and trait anxiety.

The implications of the finding that battered women suffer from the combined effects of depression and anxiety may also contribute to our current knowledge of the dynamics of leaving the abusive partner. Based on this finding, one may draw the conclusion that simultaneously experiencing these two emotional states has indirectly produced a

positive effect. It is believed that anxiety and depression manifested in the form of agitated depression had played an important role and was a determining factor in mobilizing the battered woman toward taking an active stance vis-a-vis her abusive situation.

This suggestion seems to be an integral part of Beck's (1967) cognitive theory of emotional disorders. He describes the thought content as well as the overt behavior of the agitated depressive. He believes that the attitude of the agitated patient is congruent with his/her behavior. Beck (1967) wrote:

> Unlike the retarded patient, the agitated patient does not accept his fate passively and does not believe that it is futile to try to save himself. He desperately seeks some way to ease his distress or escape from his problems. Since there is no apparent method for achieving this, his frantic search drives him into aimless motor activity such as pacing the floor, scratching his skin, or tearing his clothes. These behaviors reflect ideas such as "I can't stand this," "I've got to do something," or "I can't go on any longer this way." He also manifests these attitudes in his frenzied entreaties for help. (p. 267)

This picture of the agitated depression appears to be parallel to the condition of battered women who left their partners and went to the shelter. Many women in this study have used almost identical phrases to those mentioned by Beck when they were describing their motives for leaving the abuser.

In addition, one of the "positive" outcomes of anxiety is inherent in the patient's ability to "anticipate that certain experiences in the future might be pleasant, and that at least some of his endeavors would have a favorable outcome" (Beck, 1967, p. 268). This belief contradicts the attitude of the depressed patient who is incapable of imagining that the future would be any better than her/his present state of agony. Therefore, taking the two sets of contradictory thought

content into account, one may make the inference that, in the case of the battered woman, this mixture of experiencing both depression and anxiety has a balancing effect and leads to the outcome of seeking external help. Her overall view of self and future is neither all negative nor all positive. She starts to see that there is a glimpse of light and that there is a way out. She decides to come to the shelter. She starts to explore alternatives and to make some changes.

The findings regarding the preponderance of battered women among depressives might be explained by Brown and Harris's (1978) theory on the social origins of depression. They postulated that a causal relationship exists between emotionally significant social events and the etiology of clinical depression. They found that loss and disappointment are the central features of most events bringing about clinical depression. In fact, the loss or expected loss was related to a person with whom the woman had a close relationship--namely, her husband, her boyfriend or close confidant, or her child. The causes of such loss or expected loss were death, a life-threatening illness, a child leaving for distant places, and marital breakdown--manifested by desertion; planned or threatened separation; or the unexpected discovery of a secret liaison.

In a comparable study by Paykel (1974), two-thirds of the events found to precede the onset of depressive illness were classified as "exits," which are roughly the equivalent of what Brown and Harris classify as losses or expected losses. Brown and Harris assert that loss is a key factor in the genesis of clinical depression due to its far-reaching implications and consequences. They argue that "loss leads to

an inability to hold good thoughts about ourselves, our lives, and those close to us. Particularly important . . . is the loss of faith in one's ability to attain an important and valued goal" (p. 233).

How can we apply the concept of loss and all that it entails to explain the battered women's proneness to depression and anxiety? In the case of battered women, loss stretches far beyond the loss of an important source of positive value which can come from the partner, role identities, and ideas about marriage and family. The battered woman lives under a constant threat of literally losing her life. Many battered women are aware of the death potential as a real possibility in their relationships. Consequently, in addition to mourning the loss of what their relationships could have been, dealing with the pervasive hopelessness around the irreversibility of their distressing situation, and their perceived inability to find staisfactory alternatives, they have to encounter existentially and come to terms with their own death.

In addition, battered women, like women in general, are traditionally socialized to see marriage and the family as their primary and ultimate goals in life and are expected to be fulfilled and happy as housewives and mothers. However, this is not the case in the reality of many women, particularly those who are entrapped in abusive relationships. In fact, it has been documented that marital difficulty is the most commonly reported event in the 6 months prior to the onset of depression and the most frequent problem presented and discussed by depressed women coming for outpatient treatment (Paykel, Meyers, Dienelt, Klerman, Lindenthal, and Pepper, 1969). The most convincing evidence that social role plays a part in the vulnerability of women to

depression is the data that suggest that marriage has a protective effect for men, but a detrimental effect for women (Radloff, 1975). Thus, if depression appears to be an affliction of the married women, one may speculate that it is even more so in troubled marriages.

Even when violent marriages are viewed as dysfunctional, society's orientation is still in favor of battered women remaining in marriage regardless of the violence because of deep belief in the permanency of marriage. This tradition of valuing stable marriages and disapproving of separation or divorce further contributes to the hopelessness and powerlessness of battered women. Meanwhile, in spite of the abuse, leaving the partner symbolizes a loss of a significant source of value. Through the long-standing process of socialization, marriage is viewed by many women as the only source of self-worth and self-esteem. In this context, it is understandable that giving up the fantasy of the "happy family" may lead to devastating emotional effects. Also, battered women are told that they provoked their own assaults, that they are guilty, and that they deserve the battering. As a result, they internalize society's perception and expectation of them and assume that it is their own responsibility to make the marriage work. These internal and external pressures generate a generalized sense of failure and dissatisfaction. They feel disappointed that they were not able to meet their own aspirations concerning being a "good" mother and wife. They blame themselves and believe that it is their fault that their marriages did not represent the "happy family" cultural stereotype. Therefore, these convictions may perpetuate greater feelings of shame, guilt, anxiety, helplessness, hopelessness, and worthlessness among battered women.

The conceptual tools of Beck's cognitive theory of depression might also aid in understanding why battered women in this study constitute a clinical population for depression as was predicted. Beck (1967) postulated that the "cognitive triad" is the central mechanism which accounts for the diversified clinical symptomology of depression. According to Beck, depressive symptoms are the result of the individual's pervasive negative interpretations of experience, negative evaluations of the self, and negative expectations of the future. He argues that these three major cognitive patterns lead to the manifestation of the affective, motivational, and physical components of the depressive state.

The first component of the triad, negative view of the world, is described as the tendency of the patient to interpret life situations in a consistently negative fashion. The depressed patient views his/her experience in terms of defeat, deprivation, and depreciation. The second component is viewing self in a negative way. The depression-prone person regards him/herself as deficient, inadequate, unworthy, and undesirable. He/she tends to criticize, reproach, and blame him/herself for being inferior. The third component is described as viewing the future in a negative way. This refers to the individual's pessimistic outlook. The future is regarded as a continuation of present suffering. He/she assumes that the current state of deprivation, immobilization, and suffering will remain unchanged.

The battered woman's cognitive appraisal of her situation, self, and future appears to be in accordance with Beck's descriptions of the depressive state. As a result of experiencing repetitive physical and

emotional abuse, the battered woman's self-esteem becomes deeply wounded. She suffers from low self-esteem which is parallel to Beck's concept of "negative view of self." Almost without exception, abused women in the current study reported being emotionally and verbally abused by their partners. In fact, the results show that the escalation of psychological abuse was one of the foremost leading factors that prompted abused women to leave their partners. Abused women indicated that they were constantly criticized for not being good mothers, wives, cooks, homemakers, etc. They were repeatedly told that they were stupid, incompetent, and worthless. They were accused of being unfaithful and promiscuous. They were called "bitches" or "whores." They were blamed for provoking the violence and were told that the problems in the relationship were all their fault. Because of their extreme isolation, the batterer becomes their only frame of reference. They introject his version of the world and of them. They internalize his negative views of them, feel guilty, and blame themselves for not making the marriage work. They feel that they failed in their basic function of keeping the family intact. Thus, a negative view of self and situation prevails.

As far as the negative view of the future is concerned, abused women tend to believe that they are unable to effect change in the violent situation. They believe that, no matter what they do, the partner will continue to abuse them. The inadequate response of significant others and the social agents reinforces their feelings of helplessness and their resignation to a passive and depressed style of behavior. In addition, many women indicated that their previous attempts for change

resulted in further abuse. As a result, their expectations of the future tend to be an extension of what they experience in the present.

In light of the above, one may speculate, first, that the pretest scores are an underestimation of the intensity of depression and, second, that women who are still in abusive situations are more depressed than women who took the initial steps to put an end to the violent relationship. This argument can be supported by comments made by many women during the first interview while filling out the depression inventory. They reported feeling already better as a result of being at the shelter for 2-3 days. One woman stated, "I feel good since I got to the shelter because I did what I wanted to do. Having a place to come to make me relax and sleep. I don't have to worry about where to stay tonight and what to eat." Several women reported that they are able to sleep much better than before. One woman said, "I have not slept as well as I am sleeping now for so long."

The second hypothesis predicted that the battered women group would evidence marked reduction in depression and anxiety as a result of the treatment received at the shelter. Meanwhile, no drastic changes were expected in the non-battered women group. This hypothesis was partially supported by the results of this study. The state anxiety was the only dependent variable that was significantly reduced as a result of staying at the shelter. The posttest means of the remaining two variables of depression and trait anxiety did not significantly decrease as a result of treatment at the shelter. However, the reduction was in the predicted direction. It was observed that some gains were achieved in minimizing depressive symptomatology and trait anxiety. For

instance, while the mean pre- and post-depression scores of the control group were and stayed within the normal range, the average pre-depression scores of the battered women group dropped from the upper limit of the moderately depressed category to the lower end of the mildly depressed category. Although these changes are not statistically significant, they should not be ignored or minimized. These labels--normal, mild, moderate, and severe depression--were applied to psychiatrically diagnosed inpatients and outpatients in early validation studies of the Beck Depression Inventory (Metcalfe & Goldman, 1965).

The significant improvement in the state anxiety of battered women could be attributed to the brief, yet intensive, experience at the shelter. This reduction in the state anxiety may be accounted for by the multiple effects of experiencing the absence of the anxiety-provoking conditions, the threatening and dangerous situations of battering, coupled with living in a safe and violence-free shelter's environment. If we follow Seligman's (1974) conceptualization of the broad meaning of anxiety, it becomes easier to understand the important role that shelters play to attenuate the symptoms of anxiety. Seligman views anxiety as a state of helplessness in a no-option distressful situation. This is exactly what battered women reported to have experienced while living with their abusers and during the first few days of their stay at the shelter. This perception of helplessness is challenged by the self-help model advocated by the shelter's staff. The main premise of this model is to provide a conducive climate to empower the battered woman in taking control of her own life. Right from the very beginning, a new process of "unlearned helplessness" emerges. The

battered woman becomes actively involved in finding alternative solutions to being trapped in a violent relationship. She is encouraged to make independent decisions. She starts to plan and implement her own immediate plan of action, and gradually she feels that she is in charge of her own life. Through this process of unlearned helplessness, she also realizes that there are options to her current situation and that she is capable of surviving on her own if she chooses to do so.

In addition, the shelter provides the woman with the opportunity to examine realistically her anxieties about the uncertainty and the "unknown-ness" of the future. The new shelter's residents have the advantage of observing and identifying with other early arrivals. Residents who have made more progress become positive role models for those who are in the early stages of thinking about their violent relationships. They see for themselves that there were women who had been through similar traumatic experiences and had successfully coped with the very real problems of finding a place to live or starting a new job or dealing with the welfare system. They become more hopeful and start to believe that it is possible for them to achieve their goals and move toward independent living.

However, it is reasonable to assume that the rapid gains achieved during the brief stay at the shelter are a function of a long-standing process of internal changes that had already taken place while living dangerously with the abuser. It is believed that the women have already started to challenge their all-negative view of self, future, and world while they were entertaining the idea of leaving their abuser.

It should be kept in mind that it takes considerable courage to make the decision to leave home. It is not an arbitrary and spontaneous decision, but rather an outcome of a prolonged process of appraisal and re-evaluation of self and situation. As was reported by many women, this decision is usually made when they realize that they are able to survive on their own, when they regain their self-confidence, and when they feel ready to assume more responsibility and become in charge of their own lives. Consequently, the shelter experience facilitates and crystallizes this inner process of transformation. It aids the women in constructively channeling their freed-up energy which resulted from making the critical decision to leave home. When they arrive at the shelter, they immediately start to proceed to improve their situations.

Now, the question arises as to the meaning of the chronicity of depression and trait anxiety. Does the stability of symptoms in these two areas indicate a character disorder inherent in the personality make-up of those who are prone to become victims of abuse; or is it a result of being abused for a long period of time; or is it due to a lack of sufficient exposure to a systematic therapeutic intervention? Taking into account the limitation of our study and the brief span of treatment at the shelter, we believe that it is premature to make definitive statements. However, since the "minor" symptom's reduction was in the predicted direction, our tendency is to conceptualize the chronicity of depression and anxiety as an outcome of living under continuous danger and threat to the physical and psychological self. Based on the results of our study, it is reasonable to assume that further changes could have occurred if battered women had undergone thorough and systematic

therapeutic treatment. This argument could be supported by the Spielberger et al. (1977) view of the concept of trait anxiety. They postulate that trait anxiety may be regarded as reflecting individual differences in the frequency and the intensity with which anxiety states have been manifested in the past and in the probability that such states will be experienced in the future. By translating this definition of trait anxiety to the experience of battered women, one may speculate that the intense and recurring crises in the battered woman's home life have contributed to producing chronic anxiety rather than viewing her depression and trait anxiety as an indication of her personality predisposition to such syndromes.

This argument of viewing depression and trait anxiety as an outcome of battering might also be supported by the results of the statistical analysis of covariance. The findings of this analysis revealed that the effects of treatment have been confounded by the significant initial differences in depression and trait anxiety. These results may imply that battering, rather than sheltering, does differentiate significantly between the emotional states of those who are battered and those who are not. The results also suggest that the damage that the battering experience causes is longstanding and its cognitive and emotional consequences stretch beyond the period of cohabiting with the abuser. It is apparent that the three intensive weeks of staying at the shelter are not sufficient to completely eradicate the psychological scars that were imprinted by the battering experience.

Hypothesis three predicted that there would be a positive and direct relationship between depression and anxiety and the duration, frequency, and severity of abuse. This hypothesis, in effect, was not confirmed in most cases. The only significant relationship was found between the severity of abuse and the posttest scores of depression. This finding suggests that severity of abuse can be an important predictive factor for long-term depressive consequences. Thus, the more intense the severity of abuse, the greater the extent of long-term depression. The weak, negligible, and insignificant correlations between the three dimensions of abuse and depression and anxiety might be due to the small size of the sample. Results also might have been contaminated by the uncontrolled demographic variables and the interactional effects between variables and the interactional effects between severity, duration, and frequency.

Generally speaking, battered women in this study reported an overall positive experience at the shelter. They were appreciative of, and grateful for, each and every service they received. This almost all-positive attitude may summarize and reflect their past and present experience in their entreaties for help. One may speculate that the present foreground experience at the shelter appears to be very bright because it is in sharp contrast to their dim background experience with other social agencies, relatives, friends, neighbors, etc. In this context, Pagelow's (1977) remark is pertinent. She wrote: "Even one ounce of empathy for the battered victim will help to compensate for the countless rejections and discouragements she encounters on all sides" (p. 150).

The most obvious finding of this study is the reconfirmation of the need for continued services for battered women, particularly for providing immediate safe refuge for them and their children. One may conclude without any reservations that emergency housing and the basic physical safety it provides seems to be one of the primary needs of women escaping abusive homes and seeking to explore and identify viable alternatives to their plight.

Since the issue of wife abuse has received sufficient recognition due to the extent, severity, and the range of the problem, shelter personnel indicated that they are swamped with requests for help and that a sizable number of women needing shelter are refused for lack of space. This claim is supported by Rounsaville and Weissman (1977-78) and Scott (1974), who observed that battered women make use of services if they are available to them in order to reduce their victimization. Scott noted that "there are indications that women are increasingly willing to bring this problem to the open, a tendency which is likely to continue, especially if appropriate 'doors' are made available on which to knock" (p.435).

The concrete information derived form the present study is consistent with previous impressionistic views and provides an additional empirical documentation of the need for continued financial support of existing shelters and also the need for more shelters for battered women and their children. Therefore, in light of the consensus that emergency housing is the only major service currently available for battered women, maintaining the future continuity and basic survival of wife-abuse programs becomes an issue of paramount significance in this time of retrenchment.

The marked improvement in the posttest results on state anxiety and the partial progress made on reducing depression and trait anxiety suggest that the short-term intervention provided by the shelter is a necessary, but not sufficient, step toward the treatment of emotional disorders. It should be kept in mind that, although the severity of depression and trait anxiety changed in the predicted direction, battered women continued to experience "abnormal" states of emotional functioning. This finding confirms that further professional treatment to ameliorate depression and "trait" anxiety is warranted. Individual and/or group counseling/psychotherapy should be an essential component of the services provided by the shelter. Counseling should also be one of the main ingredients of a long-term follow-up plan. The gains women acquired during their stay at the shelter are far too important to be lost due to lack of follow-up services and continued support. It is clear that refuge is not a long-term solution. It functions as a temporary resource to assist battered women in crisis and in transition. Consequently, the "second stage" in service delivery should focus on providing help for each victim after she leaves the protective shelter environment. Follow-up services should be tailored to suit each woman's individual needs. Special survival techniques should be introduced to those who choose to go back to their mates as well as to those who decide to start new and independent lives.

Although it is beyond the scope of this study to specify remedial and/or preventive approaches to combat the problem of wife abuse and its consequences, it is our belief that the battle to eradicate violence toward women should be fought on more than one front. It goes

without saying that each and every service provided by shelters and other social agencies is important and necessary, yet not sufficient to eliminate a complex historical, socio-economic, and universal phenomenon. Dobash and Dobash's (1979) conclusion conveys very accurately the authors' mode of thinking regarding the short- and long-range goals and procedures necessary for overcoming the problem of wife abuse. They write:

> The struggle against wife beating must be oriented both to the immediate needs of women now suffering from violence and to more fundamental changes in the position of women. We now stand at a point where we may either work toward removing the very roots of wife beating by eliminating patriarchal domination or we may work only toward limited reforms which, while providing vital assistance to women currently being beaten, will do little about the problem itself. We must take up the challenge and address the issue in its fullest form, otherwise we will commit the errors of the past. The problem lies in the domination of women. The answer lies in the struggle against it. (p. 243)

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APPENDIX A
BACKGROUND INFORMATION QUESTIONNAIRE

Personal Data About You

Part I

For each question below, please circle the number which corresponds to your answer. Please answer each question. Remember, your answers are strictly confidential. There are not right or wrong answers.

1. Age

   a. 18-20
   b. 20-29
   c. 30-39
   d. 40-49
   e. 50-59
   f. 60-69

2. Marital status

   a. married first time
   b. remarried
   c. widowed
   d. divorced
   e. legally separated
   f. living with mate
   g. other _____

3. How old were you when you first married?

   a. 20 or under
   b. 21-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. over 60

4. How long have you been married?

   a. 1-5 years
   b. 6-10 years
   c. 11-15 years
   d. 16-20 years
   e. over 20 years

5. Number of previous marriages

   a. none
   b. one
   c. two
   d. three or over

6. Race/ethnicity

   a. Caucasian
   b. black
   c. Hispanic
   d. American Indian
   e. Asian
   f. other (specify) _____

7. Education

   a. grammar school or less
   b. some high school
   c. high school graduate
   d. post-secondary other than college (trade, etc.)
   e. some college
   f. college degree
   g. some graduate school
   h. graduate school

8. Employment

   a. employed part time
   b. employed full time
   c. housewife
   d. unemployed
   e. other (specify) _____

9. The total of your own individual income for last year:

   a. under $3,000
   b. $3,000-$4,999
   c. $5,000-$6,999
   d. $7,000-$9,999
   e. $10,000-$14,999
   f. over $15,000
   g. not applicable

10. The total household income for last year (combination of yours and/or mate and anyone else living with you):

    a. under $3,000
    b. $3,000-$4,999
    c. $5,000-$6,999
    d. $7,000-$9,999
    e. $10,000-$14,999
    f. over $15,000
    g. not applicable

11. Do you have any children?

    a. no (if no, skip to no. 12)
    b. yes (if yes, please fill in the blanks below regarding your children)

	Age	Sex	Live with you (check if yes)
1.	___	___	___
2.	___	___	___
3.	___	___	___
4.	___	___	___
5.	___	___	___
6.	___	___	___

12. What is the general condition of your health?

    a. excellent
    b. average
    c. poor

13. Do you have any kind of chronic physical condition for which you take medically prescribed drugs? (circle as many as apply)

    a. heart disease
    b. epilepsy
    c. diabetes
    d. arthritis
    e. migraine headaches
    f. high blood pressure
    g. blindness
    h. paralysis
    i. gastrointestinal (abdominal pain)
    j. back pain
    k. dizziness
    l. ulcer
    m. other (specify) _____
    n. N/A

14. Do you use drugs or medication on a regular basis?

    a. no (if no, skip to no. 15)
    b. yes (if yes, which of the following do you use?)

        1. marijuana
        2. amphetamines (speed, etc.)
        3. hallucinogens (LSD, etc.)
        4. minor tranquilizers (valium, librium, etc.)
        5. major tranquilizers (thorazine, etc.)
        6. sleeping pills
        7. other (specify) _____

15. Is your current relationship with husband/mate physically violent?

    a. yes
    b. no

The Nature of the Battering Experience

Part II

16. How often have you been physically attacked by the abuser?

    a. daily
    b. several times a week
    c. several times a month
    d. monthly
    e. several months apart
    f. more than a year apart
    g. hardly ever
    h. this was the first time.

17. How long have you been in this battering relationship since the occurrence of the first abusive incident?

    a. less than 6 months
    b. 6 months-1 year
    c. 1-2 years
    d. 2-4 years
    e. 4-6 years
    f. 6-10 years
    g. more than 10 years

18. How long did the first physical attack last with the current abuser?

    a. less than 5 minutes
    b. 5-15 minutes
    c. 15-60 minutes
    d. 1-4 hours
    e. all day
    f. more than 1 day

19. If you have been physically abused by the current abuser more than once, in general, how long did those attacks last?

    a. less than 5 minutes
    b. 5-15 minutes
    c. 15-60 minutes
    d. 1-4 hours
    e. all day
    f. more than 1 day

20. Prior to this incident, how many times were you physically abused?

    a. 1-5 times
    b. 6-10 times
    c. 11-25 times
    d. 26-50 times
    e. 51-10 times

21. Have the abusive incidents become more frequent over time?

    a. no
    b. yes
    c. I am not sure

22. Have injuries become more serious over time?

    a. no
    b. yes
    c. I am not sure

23. Which of the folloiwng best describes the abuser's behaviors toward you? (check all that apply)

    a. throwing objects
    b. pushing, grabbing, shoving
    c. slapping
    d. kicking, biting, or hitting with fist
    e. hitting or trying to hit with something
    f. beating up
    g. threatening with knife or gun
    h. using a knife or gun

24. Which of the following best describes the extent/severity of physical abuse you have experienced?

    a. I have not been physically hurt
    b. scrapes; bruises; cuts not needing medical attention
    c. scrapes; bruises; cuts needing medical attention
    d. breaks or possible breaks needing medical attention
    e. injury needing hospitalization
    f. not sure

25. Have you been physically abused by others as an adult?

    a. no
    b. yes (by whom) _____

26. Were you ever physically abused as a child?

    a. no
    b. yes (by whom) _____

27. Were/was previous marriages physically abusive?

    a. no
    b. yes

28. How is the abuser related to you?

    a. husband
    b. ex-husband
    c. lover/boyfriend
    d. ex-lover/ex-boyfriend
    e. other (specify) _____

APPENDIX B
EVALUATION FORM OF SHELTER EXPERIENCE

1. Is this your first visit to this shelter?

   a. yes
   b. second visit
   c. third visit
   d. fourth visit
   e. over four visits

2. How long have you been staying at this shelter?

   a. this is my first day
   b. few days
   c. one week
   d. two weeks
   e. three weeks
   f. one month
   g. two months
   h. over two months
   i. other (specify) _____

3. Have you ever been in a shelter other than this one?

   a. no (if no, skip to no. 5)
   b. yes

4. How long did you stay there?

   a. few days
   b. one week
   c. two weeks
   d. three weeks
   e. one month
   f. two months
   g. over two months

5. What was most helpful in being at this shelter?

6. What was not helpful in being at this shelter?

7. On a scale of 1 to 4, how helpful was each service to you? Use the following 4-point scale to make your ratings.

1 - not helpful at all
2 - somewhat helpful
3 - moderately helpful
4 - very much helpful
5 - service not needed
6 - service not available

1. Emergency housing	1	2	3	4	5	6
2. Legal advocacy	1	2	3	4	5	6
3. Medical assistance	1	2	3	4	5	6
4. Financial assistance	1	2	3	4	5	6
5. Employment counseling	1	2	3	4	5	6
6. Educational counseling	1	2	3	4	5	6
7. Personal/group counseling	1	2	3	4	5	6
8. Children's services	1	2	3	4	5	6
9. Transportation	1	2	3	4	5	6
10. Food	1	2	3	4	5	6
11. Clothing	1	2	3	4	5	6
12. Physical safety	1	2	3	4	5	6
13. Sharing my experience with other abused women	1	2	3	4	5	6
14. Having someone available to talk to	1	2	3	4	5	6
15. Exploring alternatives	1	2	3	4	5	6
16. Learning to make my own decisions	1	2	3	4	5	6

8. If you circles three or more of the statements, please choose three statements which best describe the services most needed by you.

a. _____

b. _____

c. _____

9a. Were there services that you neede which were not provided by the shelter?

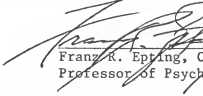
a. no
b. yes

9b. If yes, what were they?

BIOGRAPHICAL SKETCH

Lamis K. Jarrar was born on August 29, 1952, in Acre, Israel. In June 1970, she graduated from Aironie A High School in Haifa, Israel. She enrolled at Haifa University in October 1972 and received her Bachelor of Arts degree in 1976 with majors in psychology and education: theory and research. In September 1977 she started her graduate studies in counseling psychology at the University of Florida and was awarded her Master of Science degree in August 1982. She received an International Peace Scholarship for women for three consecutive years starting in September 1978. In August 1982 she was awarded a certificate for completion of a 12-month internship in counseling psychology at Southern Illinois University Counseling Center, Carbondale, Illinois. She was awarded a scholarship for two consecutive years in December 1982 from the Jerusalem Scholarship Fund. In August 1983 she received a certificate for completion of a 12-month internship training in counseling psychology at Howard University Counseling Service, Washington, D.C. Her particular areas of interest include cross-cultural counseling, feminist therapy, group and family therapy, and processes of psychosocial changes in developing countries. She plans to obtain her Doctor of Philosophy degree in August 1985.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Franz R. Epting, Chairperson
Professor of Psychology

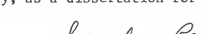
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Ted Landsman, Co-Chairperson
Emeritus Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

David Suchman
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



Jaquelyn Resnick
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert C. Tiller
Professor of Psychology

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August 1985

Dean, Graduate School